

ABOUT DR. JODIE MORELAND

Dr. Jodie Moreland

General & Cosmetic Dentistry

Dr. Moreland's Philosophy

Dr. Moreland believes that prevention, education, and care are important factors in maintaining optimum oral health. One of her main concerns is keeping up to date on the latest dental techniques and education available.

Education

Over 35 hours of continuing education every year

Nobel BioCare Implant Seminar 2001

Postgraduate Program in Esthetic Dentistry, 1997 at the University of Missouri

University of Colorado School of Dentistry, 1992

University of Colorado, Bachelors of Science, 1988

Professional Groups

American Dental Association

Colorado Dental Association

Metropolitan Denver Dental Association

Colorado Prosthodontics Society

Biography

Dr. Moreland grew up in Toledo, Ohio and moved to Colorado to attend college. After dental school, she found the love of knitting, enjoys reading, working-out, and traveling with her husband, Rob.

Jodie Moreland DDS • 5590 S. Windermere St. • Littleton, CO • 80120 • 303.798.4571 • www.drjodie.net

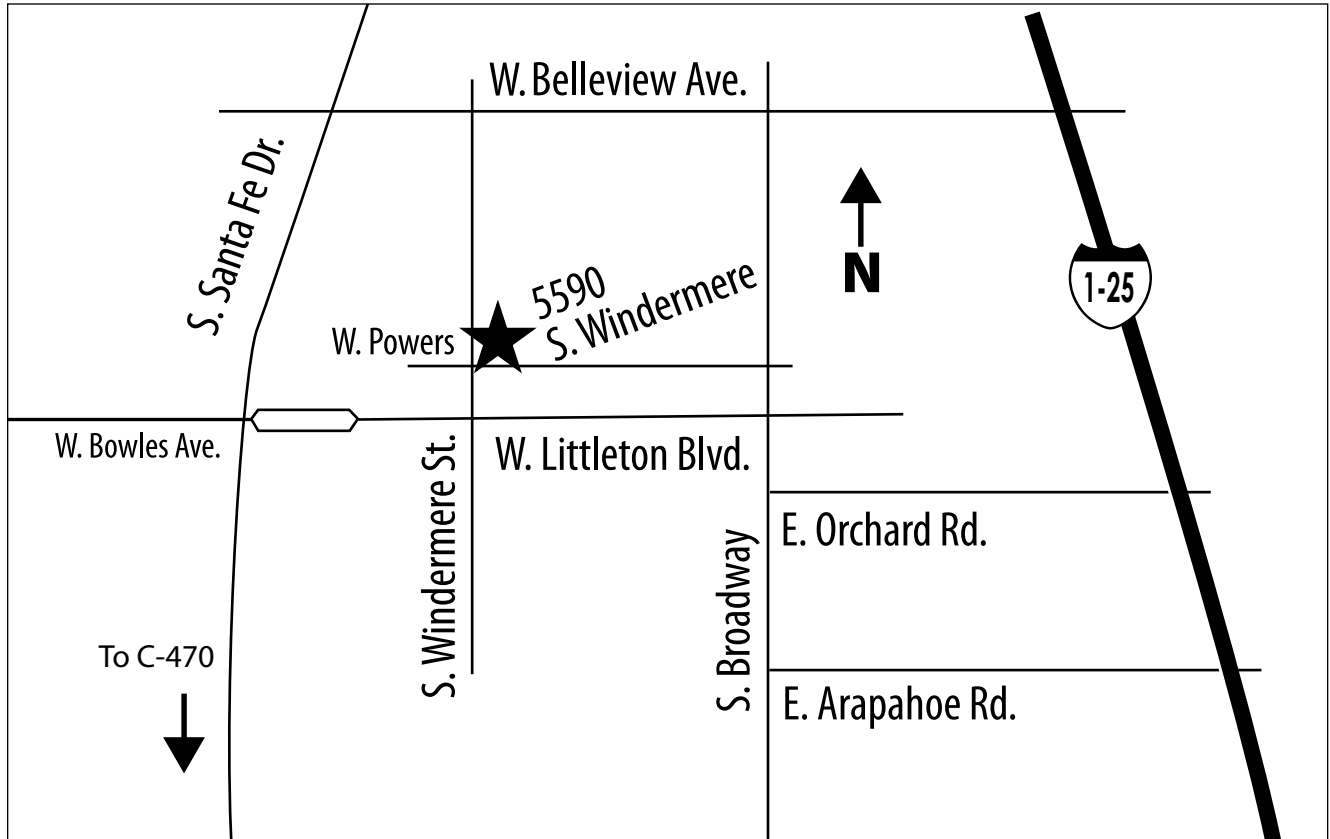
DIRECTIONS/MAP

Dr. Jodie Moreland is conveniently located just east of old downtown Littleton in a one-story brick building on the northeast corner of Powers and Windermere.

From I-25, go west on Belleview, south on Windermere.

From Santa Fe, go east on Belleview, south on Windermere.

Office hours: Monday, 8-5, Tuesday, 8-2, Wednesday, 10-6, Thursday, 8-2



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SERVICES OVERVIEW

Esthetic Dentistry

Tooth Whitening

Trays

Custom trays made for your mouth. The bleach percentage individualized for your needs.

Laser Bleaching

An in-office bleaching in one visit.

White Fillings

Composite Fillings

When replacing a small silver filling or fixing a small cavity, white fillings bond to the tooth and look natural.

Porcelain Fillings/Crowns

When a filling is over half the size of the tooth, it needs a stronger material. These fillings and crowns are made in a laboratory.

Bonding or Veneers

Bonding or Veneers over the front teeth is a great way to fill in spaces between teeth, cover stains and make teeth look straight without braces.

Implants

Implants to replace missing teeth. We restore the implant once it has been surgically placed.

Preventative Dentistry

Sealants

Sealants are a white or clear covering placed over the grooves of permanent teeth to prevent cavities. Great for children between the ages of 6 - 16.

Mouth Guards

Mouth Guards for Sports

A soft mouth-guard is essential to prevent unnecessary trauma to teeth while kids or adults are playing sports. We custom fit the mouth guard to the shape of the individuals mouth.

Night Guards

Night Guards for Clenching or Grinding

Over 65% of us clench or grind our teeth while sleeping. A night guard prevents the wear and tear on

the teeth and helps prevent headaches and muscle strain associated with clenching and grinding.

Fluoride

Fluoride is a tooth vitamin that can be topically applied in office or sold as a prescription to use daily to prevent cavities.

Cleanings

Cleanings are an essential service provided anywhere from 3 - 12 months apart. Studies have shown that the plaque buildup on teeth can be harmful to your heart. Along with the cleanings, it is important to have an exam to check for oral cancer at least once a year.

For Your Comfort

Wand-Anesthetic Machine

This machine delivers the numbing liquid at a slower rate, making it much more comfortable for you, the patient.

Virtual Reality Glasses

During your visit, these glasses allow you to watch one of our movies or even a DVD you bring from home.

Nitrous

(*laughing gas*)

Helps to reduce anxiety.

Earplugs/Headphones

Our office has earplugs available to help block out the noise if it is unpleasant to you.

Other

Partials and Dentures

These are used to replace missing teeth. We take pride in making our removable dentures to your satisfaction.

Electric Toothbrush

We sell electric toothbrushes below average retail price.

PAYMENT / CANCELLATION POLICIES

Cancellation Policy

Please help us keep the office running smoothly and efficiently.

We make every effort to stay on schedule for your benefit and convenience.

In return, we respectfully ask patients to fulfill scheduled appointments and be prompt.

Our standard office policy regarding appointments is as follows:

As a courtesy, we attempt to remind patients by telephone two business days prior to an appointment. If we are unable to contact you, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present.

That time has been reserved especially for you.

If you need to change your appointment, please contact the office at least 2 business days prior to the appointment scheduled. This will alleviate any late charge that you would normally incur.

We understand there are certain circumstances that prohibit you from doing this. Exceptions to this rule can be determined on an individual basis according to circumstances.

Insurance Policy

Thank you for taking the time to educate yourself on your particular insurance plan benefits. It is important that you understand your benefits and our office policy.

- Insurance benefits packages vary from company to company, and we will gladly assist you with your Insurance carrier before treatment.
- Please understand that NOT ALL procedures are a covered benefit in your plan. We will make every effort to know what your plan covers prior to the beginning treatment but ultimately it is your responsibility to know what is covered under your plan.
- We require your applicable deductible plus your co-payment at the time of service.

Billing Policy

We process all patient accounts through First Pacific Corporation, which states the following explanation of late and finance charges. *Late Charge:* If your minimum payment is not received by the due date you may be assessed a late payment charge. The amount of the late payment charge to be assessed is the maximum amount authorized under the laws of the state of your domicile. In most states, the late charge will be \$5.00 or 5% of the past due minimum payment, whichever is greater with a maximum of \$20.00. *Finance Charge:* The periodic finance rate is 1.25% monthly with a minimum of \$1.00 being imposed.

I have read, understand and agree to the above office policies. I understand that I am fully responsible for all fees of the services rendered, regardless of insurance coverage.

I understand that my estimated co-pay and deductible is due at the time of service.

Signature of Patient/Account Holder

Date

WELCOME FORM

About You

Today's Date: _____

Patient Name: _____

Last First MI

What you prefer to be called: _____ Male Female

Birth date: _____ Age: _____ SS#: _____

Street Address: _____

City _____ State _____ Zip _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How long? _____

Employer's Address: _____

City _____ State _____ Zip _____

Occupation: _____

Status: Minor Single Married

Spouse's Name: _____

Do you have children? Yes No How many? _____

Insurance Information

Primary Dental Insurance

Company Name: _____

Address: _____

City _____ State _____ Zip _____

Phone Number: _____

Insured's SS Number: _____

Groups Number (Plan, Local, or Policy number): _____

Insured's Name: _____

Relation: _____ Date of Birth: _____

Insured's Employer: _____

Account Information

Person ultimately responsible for this account:

Name: _____

Relation: _____

Billing Address: _____

City _____ State _____ Zip _____

Drivers License # _____

Work Phone: _____

Payment method: Cash Check

Credit Card – Enter card # (if accepted)

_____ Exp. ____ / ____

_____ Initials. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered by this office).

Emergency Contact

Who should we contact? _____

Relation: _____

Home Phone: _____

Work Phone: _____

Who is your medical doctor: _____

M.D.'s Phone: _____

Dental Information

Reason for today's visit: Exam Emergency Consultation

Are you in pain? No Yes How long? _____

Please indicate any of the following problems:

Discomfort, clicking or popping jaw Lost/Broken Fillings Stained Teeth

Red, swollen or bleeding gums Teeth Grinding Locking Jaw

Sensitive tooth, teeth or gums Ringing in Ears Bad Breath

Blisters/Sores in or around the mouth Broken/chipped Tooth

Other: _____

Do you require pre-medication? Yes No Don't Know

Previous Dentist Name _____ Phone # _____

Last Dental Exam: _____ Last Dental X-rays _____

Times of day your brush? _____ Times per week you floss? _____

What type of toothbrush bristles do you use? Soft Medium Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9

(Continued on back)

WELCOME FORM (2)

Medical History

Are you taking any of the following medications? Nerve Pills Pain Killers (including aspirin) Muscle relaxers Stimulants Blood Thinners Tranquilizers Insulin Other

Do you or have you ever had any of the following diseases or medical conditions? (Circle Yes or No)

Y N Heart Attack/Stroke	Y N Kidney Problems	Y N Cancer/Tumors	Y N Chemotherapy	Y N Heart Surg./Pacemaker	Y N Liver Problems
Y N Shingles	Y N Asthma	Y N Heart Murmur	Y N Respiratory Problems	Y N Hepatitis	Y N Difficulty Breathing
Y N Rheumatic Fever	Y N Sinus Problems	Y N HIV+/AIDS/ARC	Y N Diabetes/hypoglycemia	Y N Mitral Valve Prolapse	Y N Stomach Problems/Ulcers
Y N Arthritis/Rheumatism	Y N Leukemia	Y N Artificial Valves	Y N Psychiatric Problems	Y N Artificial Bones/Joints	Y N Anemia
Y N Heart Disease	Y N Venereal Disease	Y N Emphysema	Y N High/Low Blood Pressure	Y N Congenital Heart Defect	Y N Alcohol/Drug Abuse
Y N Fainting/Seizures/Epilepsy	Y N Bleeding Problems	Y N Chest Pains	Y N Tuberculosis TB	Y N Severe/Frequent Headaches	Y N Glaucoma
Y N Scarlet Fever	Y N Jaw Problems	Y N TMJ/TMD	Y N Frequent Neck Pain	Y N Back Problems	

Please list any other medical condition(s) you have or ever had: _____

Are you allergic to any of the following? Latex Penicillin/Amoxicillin Tetracycline Aspirin Dental Anesthetics Others: _____

Do you use tobacco? No Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10 _____ Do you wear contact lenses? Yes No

For Women: Are you taking birth control pills? Yes No _____

How many children have you had? _____

Are you pregnant? Yes No How long? _____

Are you nursing? Yes No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the Office Manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office the information I have provided.

Signature _____ Date: _____

Adult Patient Parent or Guardian Spouse

UPDATE (OFFICE USE ONLY)

Initials _____ Date _____

Comments _____

Initials _____ Date _____

Comments _____

Initials _____ Date _____

Comments _____

Initials _____ Date _____

Comments _____