

Patient Information

Name: _____
Last
First
Middle

E-Mail Address: _____ Gender: Male _____ Female _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

Home Address: _____
Street
City
State
Zip

Date of Birth: ____/____/____ Social Security Number: ____-____-____ Driver's License or ID Number: _____
MM / DD / YYYY

Responsible Party Information (If Patient is a Dependent)

Name: _____
Last
First
Middle

Relationship to Patient: _____ E-Mail Address: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone: (____) _____

Home Address: _____
Street
City
State
Zip

Date of Birth: ____/____/____ Social Security Number: ____-____-____ Driver's License or ID Number: _____
MM / DD / YYYY

Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: _____
Last
First
Middle

Primary Policy Holder's Date of Birth: ____/____/____ Primary Policy Holder's SS/ Member ID Number: ____-____-____
MM / DD / YYYY

Primary Policy Holder's Employer: _____ Rank: _____

Insurance Company Name: _____ Group Number: _____ Insurance Company Phone: (____) _____

Insurance Company Address: _____
Street
City
State
Zip

Emergency Contact Information

Local Friend or Relative not Living With You: _____ Emergency Contact Phone: (____) _____

Emergency Contact Address: _____
Street
City
State
Zip

Getting to Know You

Why did you select our office? _____ Whom May we thank for referring you? _____

Is another member of your family already a patient with our practice? _____

When was your last dental visit? _____

When was the last time you had complete dental x-rays taken? _____ Have you ever had any teeth removed? _____

How long have these teeth been missing? _____

How Have these teeth been replaced? Bridge Partial Denture Implants They have not been replaced

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

DATE

HEALTH HISTORY

Name: _____ Date: _____

Birth Date _____ Height _____ Weight _____ Age _____ Gender: M F

Please list all medical problems you are currently being treated for: _____

Please list all of your previous surgeries: _____

Please list any drug, food or latex allergies: _____

Please list your current medications: including aspirin or any other over the counter medications: _____

DO YOU HAVE, OR HAVE YOU EVER HAD....

- | | | |
|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding/blood clot problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack | <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco use | <input type="checkbox"/> Yes <input type="checkbox"/> No Anesthetic problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular heart beat | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker/defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma/eye problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers/gastric reflux |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Angioplasty/bypass | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease | <input type="checkbox"/> Yes <input type="checkbox"/> No History of alcohol or drug abuse |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Currently pregnant/nursing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No Immune system problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Hip/knee/joint replacement |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis/jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood thinners |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone density medication |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/COPD | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Require antibiotics prior to surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation therapy | |

DENTAL HISTORY (PLEASE CHECK ALL THAT APPLY):

- | | | | | |
|--|---------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Routine care only | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw/tooth trauma | <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Jaw surgery |
| <input type="checkbox"/> Gum disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Dental implants | <input type="checkbox"/> Dentures |

Please list anything else about your medical or dental history we should know: _____

Signature-Patient/Guardian

Dr's initials

UPDATED: _____ DATE: _____

COLORADO DENTAL GROUP

DENTAL INSURANCE POLICY

Colorado Dental Group proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

-----PATIENT ACKNOWLEDGMENT AND AUTHORIZATION-----

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Colorado Dental Group. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

APPOINTMENT DEPOSIT REQUIREMENT

Colorado Dental Group requires a minimum \$50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of \$300.00 or more. The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Colorado Dental Group requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature: _____ Date: _____

CANCELLATION POLICY

Colorado Dental Group makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 24 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge a \$50.00 cancellation fee for lack of proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, _____, have had the opportunity to review Colorado Dental Group's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____