

MEDICAL HISTORY



Patient Name _____

Date _____

• Personal Physician: _____ Phone: _____

• Are you currently under the care of a physician? Yes No

If yes, please explain: _____

• Have you ever been hospitalized? Yes No

If yes, please explain: _____

• Please list all medications you are currently taking including **PRESCRIPTIONS, OVER THE COUNTER & NATURAL MEDICATIONS:**

Please ✓ YES OR NO: ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING.

- Yes No **Aspirin** Yes No **Codeine** Yes No **Penicillin** Yes No **Erythromycin**
- Yes No **Local Anesthesia** Yes No **Nitrous Oxide** Yes No **Metals** Yes No **Latex Products (Gloves)**
- Yes No **Tetracycline allergy** **ANY OTHER MEDICATIONS OR SUBSTANCES:** _____

Please ✓ YES OR NO: OF THE FOLLOWING WHAT YOU HAVE HAD OR PRESENTLY HAVE:

- | | | |
|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack / Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer / Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis A, B, C or D | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia | DO YOU TAKE: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Thinners |
| <input type="checkbox"/> Yes <input type="checkbox"/> No HIV / AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Dilantin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Bones / Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No Vitamins |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent / Severe Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Use an inhaler |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No Premedication |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pace Maker | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you Pregnant/Breastfeeding | |

Any condition(s) not listed? _____ Dr. /Hyg. Initials _____

DENTAL HISTORY

PLEASE ✓ YES OR NO:

Do you have a specific dental problem? _____ Yes No .

If YES, please describe the problem _____

Are your teeth sensitive to: HOT COLD SWEETS PRESSURE _____ Yes No

Do you have dental examinations on a routine basis? _____ Yes No

Do you brush and floss on a routine basis? _____ Yes No

Have you ever had professional instructions on dental home care? _____ Yes No

Have you ever been told you have or have had **PERIODONTAL (GUM) disease?** _____ Yes No

Do your gums ever BLEED, feel TENDER or IRRITATED? _____ Yes No

Are you aware of any unpleasant odor, or taste in your mouth? _____ Yes No

PLEASE SEE OTHER SIDE

DENTAL HISTORY CONTINUED

Are you unhappy with the APPEARANCE of your teeth? _____ Yes No

If YES, please tell us why _____

Does food catch between your teeth? _____ Yes No

Do you have any loose teeth? _____ Yes No

Do you have any unreplaced missing teeth? _____ Yes No

If YES, why haven't you had them replaced? _____

Do you want to keep your remaining teeth? _____ Yes No

Have your past experiences in a dental office always been positive? _____ Yes No

Do you always have something to be treated or repaired when you visit the dentist? _____ Yes No

Are you apprehensive about dental treatment? _____ Yes No

Do you use tobacco products? Cigarettes Chew _____ Yes No

Do you ever have: CLICKING, POPPING or DISCOMFORT in the jaw joint? _____ Yes No

Do you CLENCH or GRIND your teeth? _____ Yes No

If YES, when do you notice it? At NIGHT During the DAY

Are your jaws or teeth tired when you awaken? _____ Yes No

Do you chew on only one side of your mouth? _____ Yes No

Do you have chronic headaches, neck or shoulder pain? _____ Yes No

Have you ever had pain in your jaw joint, sides of your face or ears? _____ Yes No

Have you ever experienced difficulty moving your jaw or opening your mouth? _____ Yes No

Do you wear an occlusal guard or nightguard? _____ Yes No

Have you worn BRACES on your teeth (ORTHODONTICS)? _____ Yes No

Are you deeply concerned about the finances required to return your mouth to your ideal dental health? _____ Yes No

Do you wish to talk with the dentist privately about any problems or concerns? _____ Yes No

Name of previous Dentist _____ Phone _____

What is most important to you in your dental health?

I have provided my MEDICAL and DENTAL history to the best of my knowledge. If I ever have any change in my health or if my medications change, I will inform Colorado Family Dentistry and Dr. Kasper at the next appointment without fail.

Signature _____ Date _____

Doctor Notes: Blood Pressure _____ Pulse _____ Initials _____

Colorado Family Dentistry

PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____ Social Security #: _____

Birth date: _____ Sex: **M** **F** Marital Status: _____ Spouse Name: _____

Address: _____ City: _____ Zip: _____

Home # _____ Work # _____ Cell # _____ Email: _____

Employer _____ Occupation: _____

How did you hear about our office? Mailer Internet Insurance Yellow Pages Referral Location Other

PERSON RESPONSIBLE FOR ACCOUNT – Insurance Subscriber or Head of Household

(If different from the patient)

Name: _____ Marital Status: _____ Spouse Name: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Social Security #: _____ Birth Date: _____ Relation to patient: _____

A Special Note to New Patients for Your First Visit:

A Professional Cleaning performed by a dental hygienist or a dentist is a medical procedure and must be prescribed by a qualified health care practitioner. In some cases, dental conditions exist that must be addressed before a cleaning may be possible. In these circumstances, other types of treatment may be required first in order to best provide for the health of the patient.

*Because of this, legally and ethically, an examination and diagnostic x-rays, as required by the dentist, must be done before a cleaning can be given. After a thorough examination has been performed and the x-rays have been evaluated, the doctor will determine whether or not a cleaning is the appropriate next step, or if a different procedure is required first. **Given the length and thoroughness of our examinations, the cleaning is not guaranteed to be performed at your first visit.***

Dr. Kasper and her staff are fully committed to helping their patients achieve and maintain healthy teeth and gums for the long term. The procedures we follow are in the best interest of achieving this goal for as many of our patients as possible.

I have read and understand the above message. I will take the opportunity to ask any questions I may have pertaining to this statement by phone prior to my first appointment or address the questions during my initial examination appointment.

Signature _____ Date _____

PLEASE SEE OTHER SIDE



GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks.

These risks are seldom great enough to offset the benefits of treatment, but should be considered when making your treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. Drug or chemical reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
2. Long-term numbness (paresthesia). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. Sensitivity in teeth or gums, infection, or bleeding.
5. Swallowing or inhaling small object.

While we follow procedural guidelines, which most often lead to clinical success, there are occasional cases, as in any medical treatment, that do not turn out as planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I UNDERSTAND AND CONSENT TO THE ABOVE

Patient's Signature _____ **Date** _____

Print Name _____

Parent or Guardian Signature _____ **Date** _____
(if minor)



INSURANCE INFORMATION

DENTAL INSURANCE INFORMATION (Primary Carrier)

INSURANCE CO. _____ INSURANCE CO. TELEPHONE: _____
SUBSCRIBER NAME: _____ BIRTHDATE: _____
SUBSCRIBER I.D.# _____ SUBSCRIBER SS# _____
EMPLOYER: _____ GROUP NUMBER: _____

DENTAL INSURANCE INFORMATION (Secondary Carrier)

INSURANCE CO. _____ INSURANCE CO. TELEPHONE: _____
SUBSCRIBER NAME: _____ BIRTHDATE: _____
SUBSCRIBER I.D.# _____ SUBSCRIBER SS# _____
EMPLOYER: _____ GROUP NUMBER: _____

I understand that *Colorado Family Dentistry* is willing to submit dental claims on my behalf to my dental insurance, based on the information I provide.

I recognize that my insurance is a contract between myself and the insurance company. I accept full responsibility for all dental charges incurred and acknowledge that payment for dental services are my obligation REGARDLESS OF INSURANCE or any other third-party involvement.

Signature _____ Date _____

PLEASE SEE OTHER SIDE



Consent for Assignment of Benefits and Electronic Claim Submission

I, _____, the undersigned, do hereby authorize my insurance benefits to be assigned to *Colorado Family Dentistry* and agree to the submission of electronic claims to be filed on my behalf with my insurance company.

Signature _____ Date _____

Patient's Responsibilities Regarding Insurance

I understand that *Colorado Family Dentistry, P.C.* will, as a favor to me, contact the insurance company on my behalf to try and obtain an estimation of my patient responsibility for suggested dental procedures. However, I understand that this is only an estimate and that any portion that is not covered by my insurance is my responsibility to pay in full.

Dental insurance is a contract between an employer and the insurance company. For this reason, all insurances are different and vary in their benefits. I acknowledge that the *Colorado Family Dentistry* cannot guarantee that the total estimate of benefits will be 100% accurate.

Signature _____ Date _____

OUR FINANCIAL POLICY



Thank you for choosing our practice as your dental care provider.

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

- Full payment is due prior to your treatment
- We accept Cash, Checks, MasterCard, Visa, & Care Credit

ADULT PATIENTS AND MINORS ACCOMPANIED BY ADULT

Adult patients and adults accompanying a minor patient are responsible for full payment prior to treatment.

UNACCOMPANIED MINORS

Proposed treatment sometimes changes during the procedure due to the needs of the tooth. To assure quality care of the patient, it may be necessary to proceed without the consent of the parent or the guardian. The parent or guardian is responsible for payment the day of treatment, and will be financially responsible for the necessary changes in minor's treatment.

INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND YOUR INSURANCE COMPANY.

As a courtesy to our patients, we will file your insurance claims on your behalf. We will be happy to assist you as much as we can with your insurance and to help you to receive the most benefits possible. *We do request payment of any treatment or percentage of treatment not covered by insurance at the time of service. For some insurance plans we require full payment at the time of service and the insurance company will reimburse you.* We can submit to most insurance companies, as long as your plan allows you to choose your own dentist. We do not participate in any DPO or DMO plans. *If you do not have your current insurance information or if time does not permit verification, full payment at time of service is requested.* When insurance information is received and entered after your appointment, we will complete the claim forms so that the insurance company will promptly reimburse you. We do our best to estimate fees; however insurance benefits are always subject to change. If your insurance company has not paid their portion within 45 days, the full balance will be your responsibility. You will have an additional 15 days to pay the balance.

RESCHEDULED OR MISSED APPOINTMENTS

We require the courtesy of at least 2 business days' notice should you need to reschedule or cancel your appointment. Missed appointments without 2 business days' notice are billed at *\$50.00 per hour*. Please help us serve you better by honoring your reserved appointment.

LATE ACCOUNTS

Balances over 60 days past due will be subject to 1.5% per month (18% per annum) finance charge. We reserve the right to forward accounts which are delinquent to an independent service for collection and to charge for any attorney fees incurred for the collection process.

I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY

Patient's Signature _____ Date _____

Parent or Guardian Signature _____ Date _____
(if minor)

Print Name _____

PLEASE SEE OTHER SIDE



PATIENT HIPAA CONSENT FORM
(Health Insurance Portability and Accountability Act)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (insurance company, etc.)
- The day-to-day healthcare operations of the dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. This notification is also displayed in this office for my review at any time. I understand that you reserve the right to change terms of the notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Important: If you are over the age of 18 and would like for us to be able to discuss your treatment and financial matters with parents, spouses or others, please enter the names of those whom you consent for us to discuss your treatment with:

Name of Authorized Person	Relationship to Patient
1.	
2.	
3.	
4.	

Print patient name _____

<i>Signature</i> _____	<i>Date</i> _____
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EMAIL AND VOICEMAIL COMMUNICATIONS



Please Initial the lines below stating your understanding of the following...

_____ I authorize Colorado Family Dentistry to communicate personally identifying information about me and about my dental conditions via email with other facilities required to treat my condition and with myself and others who I authorize. I understand that Colorado Family Dentistry cannot guarantee the security of email communications and I release Colorado Family Dentistry from liability for any data breaches which arise due to email communications. I understand that if I don't agree to email communications that I will need to provide for the transportation of my physical records to the offices of any other facilities aiding in my treatment.

_____ I authorize Colorado Family dentistry to leave voice messages at the phone numbers which I provide which may contain personally identifying information and information about my dental conditions. I release Colorado Family Dentistry from liability for any unintended interception of information contained within the voicemails. I understand that if I don't agree to allow Colorado Family Dentistry to leave voicemail messages that I may not be reminded of upcoming appointments or notified of other important health concerns which may have significant financial and medical consequences.