MEDICAL HISTORY: Adult

COLORADO FAMILY DENTISTRY

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*:** _____
- Have you ever taken oral or I.V. Bisphosphonates for osteoporosis? (Fosamax, Boniva, etc.) □ Yes □ No
- 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:

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

COLORADO
FAMILY DENTISTRY

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

COLORADO
FAMILY DENTISTRY

DENTAL INSURANCE INFORMATION (Primary Carrier)

INSURANCE CO. _____ INSURANCE CO. TELEPHONE:_____

SUBSCRIBER NAME: _____ BIRTHDATE: _____

SUBSCRIBER I.D.# _____ SUBCRIBER SS# _____

EMPLOYER: _____ GROUP NUMBER:_____

DENTAL INSURANCE INFORMATION (Secondary Carrier)

INSURANCE CO. _____ INSURANCE CO. TELEPHONE:_____

SUBSCRIBER NAME: _____ BIRTHDATE: _____

SUBSCRIBER I.D.# _____ SUBCRIBER 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, Discover & 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 45days, 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)

COLORADO FAMILY DENTISTRY

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.

Print patient name_____

*Signature*_____ *Date*_____

Important: **<u>If you are over the age of 18</u> 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.	

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 unencrypted 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.

Patient Name_____

Patient Signature_____ Date_____