

Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: ___ / ___ / _____ SS#: _____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient Another Dental Office Brochure Online Search
Facebook Work School Insurance Website
Sign -Drive by Walk in Other: _____

Whom may we thank for referring you to our practice? _____

Person Responsible for Account (If different from above)

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Birth Date: ___ / ___ / _____ SS#: _____

Emergency Contact

Name _____ Contact Number _____

Relationship to patient: (circle one) Spouse, Family, Other

Insurance Information (Primary)

Insured's Name: _____

Insured's Employer: _____

Insured's DOB: ___ / ___ / _____

Insurance Co: _____

ID #: _____ Group #: _____

Insurance Phone #: _____

Claims Address _____

Insurance Information (Secondary)

Insured's Name: _____

Insured's Employer: _____

Insured's DOB: ___ / ___ / _____

Insurance Co: _____

ID #: _____ Group #: _____

Insurance Phone #: _____

Claims Address _____

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____ Physician's Phone#: _____

2. Have you ever been hospitalized? Yes No

3. Have you ever had any excessive bleeding requiring special treatment? Yes No

4. **Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

5. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic Penicillin Codeine Other Antibiotic: _____

Latex Acrylic Metals Other: _____

6. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax Actonel Boniva For how long? _____

Aredia Reclast Zometa When did you stop? _____

7. Please list other medications you are taking:

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Psychiatric Treatment	Yes No	Hepatitis B	Yes No	Tobacco Products	Yes No
Sickle Cell Disease	Yes No	Hepatitis C or D	Yes No	Bruise Easily	Yes No
Sinus Trouble	Yes No	Pacemaker	Yes No	Jaundice	Yes No
Artificial Joints	Yes No	Night Sweats	Yes No	Kidney Trouble	Yes No
Thyroid Disease	Yes No	Stroke	Yes No	Diabetes	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Chemotherapy	Yes No
Blood Transfusion	Yes No	Cold Sores	Yes No	Cancer	Yes No
Mitral Valve Prolapse (MVP)	Yes No	Radiation Therapy	Yes No	Transplant	Yes No

Dental History

1. Date of last dental exam: _____ Date of last dental x-rays: _____

2. Previous dentist's name / location: _____

3. Are you having tooth or gum pain at this time? Yes No

4. Do you feel nervous about having dental treatment? Yes No

5. Have you ever had a bad experience in a dental office? Yes No

6. Do your gums bleed when brushing / flossing? Yes No

7. Have you ever seen a periodontist? Yes No

8. Have you ever had a "deep cleaning" (Scaling and Root Planning)? Yes No

9. Is there anything you would like to speak with the Doctor about in private? Yes No

10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	Yes No	Sensitivity to:	Hot	Cold	Sweets	Biting
Pain in or around your ears	Yes No	Swelling		Bleeding Gums		
Difficulty opening or closing	Yes No	Bad Taste		Bad Breath		
Difficulty chewing	Yes No	Food Catching		Tooth Pain		
History of trauma to jaw or face	Yes No	Clenching		Grinding		
Diagnosis of TMJ/TMD	Yes No	Other:	_____			

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date: _____

Doctor's Signature _____

Doctor's Notes: _____

Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all patients in obtaining the dental treatment they deserve. Therefore, we are pleased to offer several payment options. Please read the following carefully. Our financial coordinator will answer any questions you may have and assist you in selecting the appropriate financial plan for your needs.

For your convenience, we offer the following financial options:

1. In addition to personal checks and cash, we also accept payment through MasterCard/Visa, American Express, and Discover.
2. We offer extended payment plans for upon approved credit or noncredit check. (Care Credit, Lending Club, & ICare)
3. Dental Insurance

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

- Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.
 - Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days, we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.
 - We are committed to providing the highest quality of care. Our treatment recommendations and the dental services we provide are in the best interest of the patient's health. The patient is responsible for payment in full regardless of an insurance company's arbitrary determination of treatment necessity. If your coverage changes for any reason, please notify the office immediately.
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Usual and Customary Fees

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area and experience. You are responsible for payment regardless of any insurance company's arbitrary determination for usual and customary fees. All delinquent accounts not paid within 60 days will be taken further action. I have read the Financial Policy. I understand and agree to this Policy.

Payment for Surgery

For any type of surgery, a payment or a payment plan agreement must be made **1 week prior** to the date of your surgery. This ensures your surgery day and time.

Cancellations and Missed Appointments

We require 24 hours advance notice of a cancellation. Patients who do not provide 24 hours' notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice. After the second missed appointment, a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed.

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. A payment or payment plan agreement is needed 1 week prior to any Dental Surgeries. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

Signature of Patient or Responsible Party

Date

Authorization for Release of Information to Family and/or Friends

Front Range Denture & Prosthodontics – 1006 Robertson St. Build 1, Fort Collins, Co. 80524

Name of Patient _____ Date of Birth _____

Front Range Dentures & Prosthodontics is authorized to discuss my dental care and may release my confidential health information to the following:

Name Relationship

Name Relationship

Signature of Patient or Personal Representative Date

Description of Personal Representative’s Authority (attach necessary documentation)

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office’s Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature Date

-----**FOR OFFICE USE ONLY**-----

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify)