8158 East 5th Ave, Suite 150
Denver, CO 80230

303.366.3000 phone
303.366.2315 fax

About You

Today's Date:____/____/_____
Patient's Name: _____
Last First MI
Preferred Name: _____ Circle One: Male Female
Birth Date: _____ Age: ____ SSN:_____
Address:_____
_____
City State Zip
Home Phone:_____
Work Phone:_____ Ext: _____
Other Phone:_____

Email Address: _____
Referred by:_____

Employer:_____
Employer Address: _____
_____
City State Zip
Occupation:_____

Status: Minor Single Married Divorced Separated Widowed
Spouse's Name:_____
Do you have children? _____ How Many? _____

Account Information

Person ultimately responsible for the account:
Name:_____
Relation:_____
Billing Address:_____
_____
City State Zip
SSN:_____
Driver's License:_____
Other Phone:_____

Circle Payment Method: Cash Check Credit Card
CC Number: _____ Exp: _____

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 by my insurance company.

Signature:_____

Insurance Information

Primary Dental Insurance
Insurance Co. Name:_____
Address:_____
_____
City State Zip
Phone Number:_____
Group or Policy number:_____
Insured's Name:_____
Insured's SSN:_____
Relation:_____ Birth Date: _____
Insured's Employer:_____

Secondary Dental Insurance
Insurance Co. Name:_____
Address:_____
_____
City State Zip
Phone Number:_____
Group or Policy number:_____
Insured's Name:_____
Insured's SSN:_____
Relation:_____ Birth Date: _____
Insured's Employer:_____

In the Event of an Emergency

Who should we contact?_____
Relation:_____
Home Phone:_____
Work Phone :_____ Ext:_____
Who is your medical doctor?_____
M.D.'s Phone :_____
M.D.'s Address:_____

SERVICE CHARGE
If I do not pay the entire balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.
Signature:_____

Medical Health, Adult

Patient's Name:_____ Patient's Age :_____

General Health: Excellent □ Good □ Fair □ Poor □

Date of Last Complete Physical Exam:_____

Are you taking any prescription or over-the-counter drugs? Yes □ No □

If Yes, please list each one:_____

Have you ever been treated, are currently being treated, or have been advised to seek treatment for:

Blood Pressure (high or low)	yes □	no □	Glaucoma	yes □	no □
Heart Attack	yes □	no □	Kidney Disease	yes □	no □
Heart Surgery	yes □	no □	Thyroid Disease	yes □	no □
Heart Murmur	yes □	no □	Arthritis	yes □	no □
Congenital Heart Lesions	yes □	no □	Rheumatism	yes □	no □
Artificial Heart Valve	yes □	no □	Liver Disease	yes □	no □
Heart Pacemaker	yes □	no □	Ulcers	yes □	no □
Congestive Heart Disease	yes □	no □	Hepatitis A	yes □	no □
Mitral Valve Prolapse	yes □	no □	Hepatitis B	yes □	no □
Chest Pains/Angina Pectoris	yes □	no □	Hepatitis C	yes □	no □
Stroke	yes □	no □	Alcohol Addiction	yes □	no □
Surgical Shunt	yes □	no □	Drug Addiction	yes □	no □
Plate or Pins	yes □	no □	Cancer / Tumors	yes □	no □
Artificial Joints or Implants	yes □	no □	Chemotherapy	yes □	no □
Rheumatic Fever	yes □	no □	HIV	yes □	no □
Anemia	yes □	no □	AIDS	yes □	no □
Hemophilia	yes □	no □	Psychiatric Condition	yes □	no □
Diabetes	yes □	no □	Fen-Phen or Redux taken	yes □	no □
Epilepsy	yes □	no □	*Women*		
Tuberculosis or Lung Disease	yes □	no □	Taking Birth Control?	yes □	no □
Emphysema	yes □	no □	Are you pregnant?	yes □	no □
Sinus Trouble	yes □	no □	Are you nursing?	yes □	no □
Asthma or Hay Fever	yes □	no □			

Are you allergic to or have you reacted adversely to any of the following drugs?

□ Penicillin □ Aspirin □ Erythromycin □ Latex □ Codeine □ Tetracycline □ Sulfa

□ Dental Anesthetics □ Nitrous Oxide □ Ibuprophen

Please list any other drugs that you are allergic to:_____

Other physical conditions we should be aware of:_____

I understand that the information I have given today regarding my medical health history is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes to my medical status. Signature: _____ Date: _____

Thank you for taking the time to fill this form out completely. It will enable us to help you more effectively.
If you have any questions, please be sure to ask. We are always happy to help!

Dental Health, Adult

Are any of your teeth sensitive to:

Hot ..... yes ☐ no ☐
Cold ..... yes ☐ no ☐
Sweets ..... yes ☐ no ☐
Biting or Chewing ..... yes ☐ no ☐

Have you recently experienced:

Odors or bad taste in your mouth? ..... yes ☐ no ☐
Bleeding or painful gums? ..... yes ☐ no ☐
Any change in your bite or loose teeth? ..... yes ☐ no ☐
Food caught between your teeth? ..... yes ☐ no ☐
If yes, where? _____

Have you ever experienced:

Clicking or popping of the jaw? ..... yes ☐ no ☐
Pain? (joint, ear, side of face) ..... yes ☐ no ☐
Difficulty in opening or closing mouth? ..... yes ☐ no ☐
Difficulty in chewing on either side of the mouth? ..... yes ☐ no ☐
Headaches, neck aches, or shoulder aches resulting from tension in your jaws? ..... yes ☐ no ☐
Tired jaws, especially in the morning? ..... yes ☐ no ☐

Do you:

Clench or grind your teeth while awake or asleep? ..... yes ☐ no ☐
Bite your lips or your cheeks regularly? ..... yes ☐ no ☐
Hold foreign objects with your teeth? (pencils, pipe, pen, nails, etc.) ..... yes ☐ no ☐
Mouth breathe while awake or asleep? ..... yes ☐ no ☐
Frequently get cold sores, blisters, or any other lesions? ..... yes ☐ no ☐

Have you ever had:

Orthodontic treatment? Including braces, retainers. ..... yes ☐ no ☐
Oral surgery? ..... yes ☐ no ☐
Periodontal treatment? Including gum surgery or deep cleanings ..... yes ☐ no ☐
A custom fitted mouth guard / occlusal guard / night guard? ..... yes ☐ no ☐
A serious injury to the mouth or head? ..... yes ☐ no ☐
If so, please describe, including the cause: _____

Do you currently or have you ever used the following tobacco products?

Cigarettes / Cigar / Pipe ..... yes ☐ no ☐
Chewing tobacco (dip, snuff) ..... yes ☐ no ☐

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