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 and Dental Health, Child

Patient's Name:________________________ Patient's Age :___ Patient's Date of Birth: _______

General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Date of Last Complete Physical Exam:___________ Name of Physician: _________________________

Date of Last Dental Exam: ____________________ Were x-rays taken? Yes ☐ No ☐

Is your child taking any prescription or over-the-counter drugs? Yes ☐ No ☐

If Yes, please list each one:____

Has your child ever been treated, currently being treated, or have been advised to seek treatment for the following conditions?

Medical History

AIDS / HIV Positive .... yes ☐ no ☐
Allergies .... yes ☐ no ☐
Asthma .... yes ☐ no ☐
Cancer .... yes ☐ no ☐
Diabetes .... yes ☐ no ☐
Epilepsy .... yes ☐ no ☐
Hearing Loss .... yes ☐ no ☐
Heart Murmur .... yes ☐ no ☐
Heart Problems..................... yes ☐ no ☐
Liver Problems……………...yes ☐ no ☐
Lung Problems .... yes ☐ no ☐
Kidney Infections................. yes ☐ no ☐
Rheumatic Fever .... yes ☐ no ☐
Speech Impairments............. yes ☐ no ☐
Seizures……..………………yes ☐ no ☐
Vision Problems…………….yes ☐ no ☐

Dental History

Dental Pain .... yes ☐ no ☐
Injuries to Mouth .... yes ☐ no ☐
Thumb Sucking .... yes ☐ no ☐
Nail Biting .... yes ☐ no ☐
Pacifiers .... yes ☐ no ☐
Eat between meals .... yes ☐ no ☐
Eat sweets .... yes ☐ no ☐
Drink sodas .... yes ☐ no ☐
Brush teeth in AM .... yes ☐ no ☐
Brush teeth in PM................. yes ☐ no ☐
Brush own teeth .... yes ☐ no ☐
Like his/her teeth .... yes ☐ no ☐

Is your child allergic to or 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 your child is allergic to:____

Other physical or health conditions we should be aware of: ____

I understand that the information I have given today regarding my child's medical and dental 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 child's medical or dental status.

Signature of Parent or Guardian: ________________________________ 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!