PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PATIENT OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

IF PT IS A STUDENT, NAME OF SCHOOL _____

CITY _____ **STATE** _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

CONFIDENTIAL

BIRTHDATE
_____

SS NUMBER
_____

CELL PHONE
_____

EMAIL
_____

CIRCLE APPROPRIATE SELECTION:

MINOR SINGLE MARRIED

DIVORCED WIDOWED SEPERATED

HOME PHONE
_____

WORK PHONE_____

OTHER
_____

RESPONSIBLE PARTY (If different from above)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

_____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

EMPLOYER _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

RELATIONSHIP TO PATIENT
_____

HOME PHONE
_____

WORK PHONE
_____

CELL PHONE
_____

BIRTHDATE
_____

SS NUMBER
_____

INSURANCE INFORMATION

NAME OF INSURED _____ **INSURANCE COMPANY** _____ **ADDRESS** _____ **CITY** _____ **STATE** _____ **ZIP** _____ **PATIENT SIGNATURE** _____	**RELATIONSHIP TO PATIENT** _____ **BIRTHDATE** _____ **SS NUMBER** _____ **GROUP NUMBER** _____ **INSURANCE PHONE** _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulpha		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus)_____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux)_____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma_____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth_____	☐	☐
35. hives, skin rash, hay fever_____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth_____	☐	☐
40. radiation therapy_____	☐	☐
41. chemotherapy_____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment_____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements_____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed_____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist: _____ How long were you a patient? _____Months/Years

When was your last exam and cleaning? _____

WHAT IS YOUR IMMEDIATE CONCERN? _____

_____

PLEASE ANSWER THE FOLLOWING:

1. On a scale of 1 (least) to 10 (most), how fearful are you of dental treatment? **1 2 3 4 5 6 7 8 9 10**
2. Have you had any complications or unfavorable dental experiences? **Yes/No**_____
3. Have you ever had trouble getting numb or had any reactions to local anesthetic? **Yes/No** _____
4. Did you ever have braces or orthodontic treatment? **Yes/No** _____
5. Do you clench or grind your teeth during the day and/or at night? **Yes/No** _____
6. Do you have chronic headaches, neck, or shoulder pain? **Yes/No** _____
7. Are your teeth or jaw joints sore or tired when you wake up? **Yes/No**_____
8. Does your jaw painfully click or pop when you open your mouth? **Yes/No**_____
9. Have you ever experienced difficult moving your jaw or opening your mouth wide? **Yes/No**_____
10. Do you chew on only one side of your mouth? **Yes/No**_____
11. Is there anything about the appearance of your teeth that you'd like to change? **Yes/No** _____
12. Are your teeth crowding or developing spaces? **Yes/No** _____
13. Have you had any cavities within the past 3 years? **Yes/No** _____
14. Does your mouth seem dry sometimes? **Yes/No** _____
15. Are any teeth sensitive to hot, cold, sweets, or chewing? **Yes/No** _____
16. Do you get food caught between any teeth? **Yes/No** _____
17. Do your gums bleed when brushing or flossing? **Yes/No** _____
18. Have you ever been treated for gum (periodontal) disease or had a deep cleaning? **Yes/No**_____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

OFFICE POLICY AND CONSENT FORM

Thank you for choosing our practice for all of your dental care needs. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. These financial guidelines are intended to facilitate excellent service to you while minimizing our administrative costs.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
  We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
  Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash. Outside financing is available through Care Credit and Compassionate Health Care upon request.
- Regarding divorce and billing problems: This office is not a party to any divorce decrees. We may bill the responsible party (or guardian) that is present for treatment. Any collection fees, court costs, reasonable attorney fees, or returned check fees are responsibility of the adult person(s) named on the account.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 2 business days' notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $50.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $50 cancellation fee will be assessed for the first individual and $25 for each family member thereafter.**
- Our office will provide confirmation calls, emails and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm you appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature _____(Patient, Parent or Guardian)

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 303-825-3818.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Corson Dentistry does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. *Safeguarding Your*

Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Corson Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Corson Dentistry.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Corson Dentistry occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

_____

Patient Print

_____ _____

Patient Signature Date