Affordable Dental

Thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care.Please fill out this form completely. If you have any questions or need assistance, please ask us we will be happy to help.

Today's Date_____

Patient Information

Last Name: _____ First name: _____ Middle Initial: _____

Preferred Name: _____

Date of birth: ___/___/___ Sex: M___ F___ Social Security Number_____---_____---_____

Address: _____City: _____State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

E-mail: _____

Check appropriate box: Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Emergency Contact

Last Name: _____ First Name: _____

Relationship to patient: _____ Contact Number: _____

Responsible Party

Name of Responsible Party (guardian):_____

Social Security Number_____---_____---_____ Date of Birth: ____/____/_____

Address (if different than patient): _____
City: _____State:_____ Zip: _____

Employer/Company Name:_____ Phone Number: _____

Address: _____ City: _____State:_____ Zip: _____

Whom may we thank for referring you? _____

Dental Insurance Information

Insurance Company: _____ Policy Holder: _____

Date of Birth: ___/___/____ Social Security Number_____---_____---_____

Subscriber Id Number: _____ Group Number: _____

Employer/Company Name: _____

Insurance Co Address: _____Phone Number: _____

Secondary Insurance Information (if applicable)

Insurance Company: _____ Policy Holder: _____

Date of Birth: ___/___/____ Social Security Number_____---_____---_____

Subscriber Id Number: _____ Group Number: _____

Employer/Company Name: _____

Insurance Co Address: _____Phone Number: _____

Consent for Treatment

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered I understand that providing incorrect information can be dangers to my health. I hereby authorize Affordable Dental to administer and preform the necessary procedure such as x-rays, anesthetics and dental treatment deems necessary or advisable with the diagnosis of my dental condition. I understand there is certain risk inherent in the dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia, and other procedure specific risk.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during mi ineligible insurance period and any balance not paid by the insurance carries. I understand that the insurance are billed as a courtesy and that I am ultimately responsible for all cost of treatment. **Co-pay is only an estimate.**

Responsibility for Payment: In the event that this matter is turned over to a collections agency or attorney for collection of any fees due herein; I hereby agree to pay all collection agency fees and attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court cost incurred in making collections sums due unpaid for the work herein set forth.

Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental History

Name of previous dentist: _____Last Dental Visit: _____

Reason for today's visit? _____

Have you ever had a serious problem with a previous dental treatment? Yes [ ] No [ ]

If "Yes" explain: _____

How often do you brush? _____ How often do you floss? _____

How often do you get a cleaning? _____

Please answer YES [ ] or NO [ ]

Are you hesitant to come to the Dentist? Yes [ ] No [ ]

Do you snore or have trouble sleeping? Yes [ ] No [ ]

Do your gums bleed during brushing or flossing? Yes [ ] No [ ]

Do you have a bad taste or order in your mouth? Yes [ ] No [ ]

Does food frequently get caught between your teeth? Yes [ ] No [ ]

Do you have dental fillings that you don't like? Yes [ ] No [ ]

Would you like to have a whiter and brighter smile? Yes [ ] No [ ]

Would you like a straighter smile? Yes [ ] No [ ]

Do you have missing teeth that you want to replace? Yes [ ] No [ ]

Do you have loose dentures or partials? Yes [ ] No [ ]

Are you wearing away your teeth? Yes [ ] No [ ]

Do you grind or clench your teeth? Yes [ ] No [ ]

Any sensitivity? Yes [ ] No [ ] if "yes" where _____

What do you NOT like about your smile?

_____

What can we do to make your smile look better?

_____

Appointment Policy

To make sure that every patient gets our individual attention, we set aside a dedicated time for each appointment. If you are unable to keep your scheduled appointment, please notify us 24 hours in advance so we can accommodate other patients. Our No-show/Cancellation policy is as follow: We schedule our patients per appointment because you deserve exclusive, personalized time with the doctor and staff. Our office strives to see every patient at their appointment time. In order for us to do that, it is important that you arrive on time. If you are late by 15 minutes or more, your appointment may take longer than scheduled or may be rescheduled for a different date and time. ***If three appointments are missed we reserve the right to discontinue seeing you at this office.*** Phone cancellations will only be accepted during business hours and NOT when the office is CLOSED. Messages left on voicemail for appointment changes or cancellations will not be accepted, you must speak to a team member during our regular office hours.

I, _____ understand and agree to the following policy. (Patient or Guardian Printed Name)

OUR NOTICE OF PRIVACY PRACTICE & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. By, Law we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office and post it on our website.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: **Affordable Dental 3216 High St Denver Co 80205. Phone 303-394-0231**

Right to Revoke: You have the right to revoke this consent of our use and disclosure of your protected health information at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke your consent.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO AFFORDABLE DENTAL I ACKNOWLEDGE THAT I RECEIVED A COPY OF AFFORDABLE DENTAL'S NOTICE OF PRIVACY AND POLICIES.

Print Name of Patient or Responsible Party: _____

Signature of Patient or Responsible Party: _____ Date_____

PRESCRIPTION DRUG MONITORING NOTIFICATION

By signing this form, you confirm that you have been notified that if you receive a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado, certain identifying prescription information, including the name of the patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses of controlled substances – like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances (narcotic drugs like painkillers, muscle relaxants and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants or any other category of prescription medication.

Only authorized individuals like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstances can access the database and only for tightly defined uses. As long as you are using controlled drugs appropriately, there shouldn't be reason for concern. If you do not want your information in the database, please ask your dentist to prescribe non-narcotic drug for you.

More information about Colorado's prescription drug monitoring program, including copies of individual prescription drug records stored in the database, can be obtained from the Colorado state Department of Regulatory Agencies by calling 303-894-5957 or by visiting http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm

I have read and understand this notification.

_____ _____

(Signature of patient/guardian) (Date)

If this notification is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient:

_____