

Patient Information

- CONFIDENTIAL -

Today's Date: _____

Patient Personal Information

Name: _____ Sex: Male Female

Address: _____ Apt./Lot #: _____

City: _____ State: _____ Zip: _____

We use both your cell phone and e-mail to confirm your appointments

Cell Phone: () _____ - _____ Email: _____

Soc. Sec. #: _____ - _____ - _____ Birth date: _____ Age: _____

Person to contact in case of emergency: _____ Phone: () _____ - _____

If Patient is a minor, Responsible party information:

Name: _____ Sex: Male Female

Address: _____ Apt or Lot #: _____

City: _____ State: _____ Zip: _____

Insurance Information - Primary Holder Information:

Name of *person insured*: _____ Relationship to Patient: _____ or Self

Birth Date: _____ Social Security #: _____

Address of *Person Insured* if different: _____

Insurance Company: _____ Medicaid #: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Do you have any additional Insurance? YES NO If yes, complete the following:

Name of *person insured*: _____ Relationship to Patient: _____

Address of *Person Insured* if different: _____

Birth date: _____ Social Security #: _____

Name of Employer: _____ Work Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Medicaid #: _____

Patient Medical/Dental History

Referring Office Name: _____ Doctor Name: _____ Office Phone: _____

Medical Information

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you under medical treatment now? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any Surgical operation or serious illness? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____ | | |
| 3. Are you taking any medication(s), including any non-prescription medicine? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____ | | |
| 4. Have you ever taken Phen-Fen/Redux? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco or Marijuana? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have history of drug use? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have history of alcoholism? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Allergy Information

1. Are you allergic to or have you had any reactions to any of the following? Yes No
- | | | |
|---|--------------------------|--------------------------|
| - Local Anesthetic (e.g. Novocain) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Penicillin or other Antibiotics _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Sulfa Drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Barbiturates _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Sedatives _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Iodine _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Aspirin, Motrin, Aleve or Ibuprofen _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Any Metals (e.g. nickel, mercury, etc.) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Latex Rubber _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Other (please list) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
2. Women Only:
- a) Are you pregnant or think you may be pregnant? Yes No
- _____
- b) Are you nursing? Yes No
- _____
- c) Are you taking oral contraceptives? Yes No
- _____
- Antibiotics may stop the effectiveness of Birth Control Pills**

Medical History

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

- | | Yes | No | | Yes | No | | Yes | No |
|-------------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| High Blood Pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack _____ | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker _____ | <input type="checkbox"/> | <input type="checkbox"/> | Stroke _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur _____ | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of limbs _____ | <input type="checkbox"/> | <input type="checkbox"/> | Angina _____ | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures _____ | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired _____ | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | Anemia _____ | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema _____ | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions _____ | <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____ | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia _____ | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis _____ | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes _____ | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement _____ | <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases _____ | <input type="checkbox"/> | <input type="checkbox"/> | Joint Implant _____ | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV _____ | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Diseases _____ | <input type="checkbox"/> | <input type="checkbox"/> | Blood Diseases/coagulation disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Malignant Hyper-thermia _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia _____ | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis Medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Fibromyalgia _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Dental History

Name of previous Dentist and location: _____ Date of last Exam: _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? _____ | | | 14. Do you wear dentures or partials? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking? _____ | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date of placement _____ | | |
| Pain (joint, ear, side of face)? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions Regarding the care of your teeth and gums? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any adverse effects from dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Do you wish to talk to the doctor privately about anything? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, please explain? _____ | | | | | |

Authorization and Release

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 dangerous to my health. I authorize the oral surgeon to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such health/dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the oral surgeon insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent if minor)

Doctor Comments _____ Revision 08

Financial Policy & Notice of Privacy Practices

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at this time. Your clear understanding of our Financial Policy is important to our professional relationship.

We must emphasize that as a health care provider, our relationship is with *you*, not with your insurance company.

- Your insurance is a contract between you, your employer and the insurance company.
- Phone and written confirmation of your co-pay is not necessarily a guarantee of payment.
- Required co-payments must be made on the Due-date given by our office.
- **YOUR CO-PAY IS ONLY AN ESTIMATE. You are responsible for balance not paid by your insurance company.**

Payment for services is due at the time service is rendered, unless payment arrangements have been approved in advance by our office. You are responsible for timely payment of your account.

Late payments will be subject to a 24% APR late fee. If applicable, you will be responsible for any lawyer and/or Collection Agency expenses that may be incurred. All discounts given will be revoked if payment/balance is not paid by the due date.

I have read the above information; I understand and agree that I am responsible for the payment of all professional services rendered.

Acknowledgement of Receipt of Notice of Privacy Practices

I am aware of this office Notice of Privacy Practices.

Patient acknowledgment for above information:

Signature _____

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 medications.

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 303-849-5957 or by visiting <http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm>

I have read and understand this notification.

Date

(Signature of patient/guardian)

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

Personal Representative's Name: _____

Relationship to Patient: _____

Oral Surgery Center

I.V. Sedation Patients

I.V. sedation is **NOT** complete sleep. It is a medication given through an IV to relax you. Some of the reactions you might encounter are:

- Feeling relaxed
- Breathing will slow down
- Blood pressure will drop a little
- Feeling emotional (laughing or crying)

During your full procedure, you will be attached to a heart/breathing monitor and you will be monitored by your doctor and nurses.

You may not remember your surgery and you will be able to respond to your doctor through verbal stimulation.

If you desire complete sleep (General Anesthesia), please ask your doctor so you can be referred to a hospital.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____