Emerald Dental

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12093 W. Alameda Pkwy, Ste A • Lakewood, CO 80228 (303)716-7321

Welcome to Emerald Dental

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

Emergency Contact's Name, Phone Number and Relationship *

_____

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Responsible Party Information:

Are you the responsible party? If no, please complete this section. * ◯ Yes ◯ No

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Company Phone Number:

Secondary Dental Insurance

Name of Insured: _____ _____ _____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Primary and Secondary Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance.

Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 48 hours. There will be a fee of $45.00 per hour assessed if we do not receive a call to cancel an appointment.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Cancellation Policy**

HIPAA

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of oral health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

The office reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically grant permission of my protected health care information to include treatment, account information to the persons indicated below.(Please enter name and relationship)

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Authorization For Use Or Disclosure Of Patient's Photo's and/or Video Images

Authorization:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the office. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images.**

Response Date: _____

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Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Are you now under the care of a physician? * ◯ Yes ◯ No

If yes, please explain:

_____

_____

Have you had any serious illnesses, or have been hospitalised in the last 5 years? If yes please explain

_____

_____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Premed-Amoxicillin
- ☐ Allergy-Anesthetic
- ☐ Allergy-Cephlasporin
- ☐ Allergy-Entex
- ☐ Allergy-Latex
- ☐ Allergy-NSAIDS
- ☐ Allergy-Penicillin
- ☐ Allergy-Tylenol
- ☐ Arthritis
- ☐ Bleeding-Excessive
- ☐ Blood Thinners
- ☐ Cardiovascular Disea
- ☐ Circulatory Problems
- ☐ Dizziness/Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart- Murmur
- ☐ Heart-CHF
- ☐ Immune Deficiency
- ☐ Mental Disorders
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Respiratory/COPD
- ☐ Seizures
- ☐ Spinal Stenosis
- ☐ Thyroid Condition
- ☐ Vision Loss
- ☐ *Premed-Clindamycin
- ☐ Allergy-Aspirin
- ☐ Allergy-Clindamycin
- ☐ Allergy-Epinephrine
- ☐ Allergy-Levofloxacin
- ☐ Allergy-Naproxin
- ☐ Allergy-Seasonal
- ☐ Allergy-Vicodin
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Blood-Clotting
- ☐ Cerebral palsy
- ☐ Crohns Disease
- ☐ Epilepsy
- ☐ Growths
- ☐ Headaches
- ☐ Heart- Pacemaker
- ☐ Heart-Mitral Valve
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Osteopenia
- ☐ Pre-Diabetic
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ x Other Note Below
- ☐ ADD/ADHD
- ☐ Allergy-Benzodiazapi
- ☐ Allergy-Codeine
- ☐ Allergy-Gluten
- ☐ Allergy-Medication
- ☐ Allergy-Other
- ☐ Allergy-Sulfa
- ☐ Allergy-Warfarin
- ☐ Asthma
- ☐ Blood Pressure-High
- ☐ Brain Surgery
- ☐ Chemotherapy
- ☐ Dental Anxiety
- ☐ Fibromyalgia
- ☐ HIV/AIDS
- ☐ Hearing Loss
- ☐ Heart- Problems
- ☐ Hepatitis
- ☐ Knee Surgery
- ☐ Narcolepsy
- ☐ Osteoporosis
- ☐ Psychiatric care
- ☐ Rheumatism
- ☐ Sleep Apnea
- ☐ TMJ Disorder
- ☐ Tumors
- ☐ Allergy-Amoxicillin
- ☐ Allergy-Cephalexin
- ☐ Allergy-Compazine
- ☐ Allergy-Ibuprofen
- ☐ Allergy-Metronidazol
- ☐ Allergy-Oxycodone
- ☐ Allergy-Toprol
- ☐ Anemia
- ☐ Autism
- ☐ Blood Pressure-Low
- ☐ Cancer
- ☐ Chronic Headaches
- ☐ Diabetes
- ☐ GERD/Ulcers/Reflux
- ☐ Hay Fever
- ☐ Heart- Disease
- ☐ Heart-A-fib
- ☐ Hip Replacement
- ☐ Liver Disease
- ☐ Nervous Conditions
- ☐ Other
- ☐ Radiation Treatment
- ☐ STI's
- ☐ Smoker/Vaper
- ☐ Thallasemia
- ☐ Vertigo

☐ Recent hospitalization (illness or injury)
☐ Presently being treated for any other illnesses/conditions
☐ Tobacco Use- Smoke, Vape or Chew
☐ Alcohol Dependancy
☐ Chemical Dependency
☐ Persistant cough greater then 3 weeks
☐ Cough that produces blood
☐ Been exposed to anyone with Tuberculosis

If any conditions or alerts selected above need further clarification, please describe below:

Women Only:

Please select all the apply:

☐ Currently Pregnant ☐ Currently Nursing ☐ Currently taking Birth Control ☐ Trying to get pregnant(Invitro)
☐ Hormone Replacement Therapy

Bone Density Treatment

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? If yes treatment began

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax?) or risedronate (Actonel?) for osteoporosis or Paget's disease?

◯ Yes ◯ No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? * ◯ Yes ◯ No

Do you take antibiotic premedication for your dental visits? * ◯ Yes ◯ No

Please explain your need to premedicate: *

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

Are you taking or have recently taken prescription or over the counter medication? ◯ Yes ◯ No

If so, please list all including vitamins, herbal, natural and or dietary supplements

Please list any medications you are currently taking, one medication per line:

Physician Name and Phone Number:

Pharmacy Name and Phone Number

Dental History

Previous Dentist Name and Phone Number:

Reason for leaving your previous Dentist? * _____

Date of most recent dental exam and dental x-rays:

When was your last dental cleaning? * _____

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is the reason for your dental visit today?

Is there anything about the appearance of your smile that you would like to change?

Please check all that apply:

- ☐ Gums bleed when you brush or floss
- ☐ Bad mouth odor
- ☐ Have broken fillings
- ☐ Teeth sensitive to cold, hot, sweets or pressure
- ☐ Periodontal(gum) treatment
- ☐ Had any problems associated with previous dental treatment
- ☐ Currently experiencing dental pain or discomfort
- ☐ Have any clicking, popping, or discomfort in the jaw
- ☐ Have/had sores or ulcers in your mouth
- ☐ Have/had a serious injury to your head or mouth
- ☐ Food gets trapped in spaces
- ☐ Have/had loose teeth
- ☐ Missing teeth
- ☐ Experience Dry Mouth
- ☐ Orthodontic treatment(braces)
- ☐ Drink bottled or filtered water
- ☐ Have/had earaches, or neck pain
- ☐ Brux or grind your teeth
- ☐ Wear dentures or partials

Sleep Apnea:

Please check all that apply:

- ☐ Snore Loudly
- ☐ You stop breathing, choke or gasp during your sleep
- ☐ Feel fatigued or sleepy during the daytime
- ☐ Currently use CPAP

If any of the checked boxes need further explanation, please describe:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: _____