



Patient Registration

Patient's Name: _____ Date of Birth: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home Phone. # _____ Cell Phone. # _____

Your Employer _____ Work Phone. # _____

Soc. Security #: _____ E-mail address: _____

Marital status: Single Married Widow Separated

Are you a full time student? _____

If patient is a minor, we need: Mother's DOB: _____ Father's DOB: _____

Responsible Party Name: _____

Relationship: _____ Spouse's/Parents: Soc Security # _____

Driver's License #: _____ Spouse's/Parent's Phone #: _____

Emergency Contact name, address and telephone of a relative not living with you:

How did you hear about our office?

Dental Insurance information (Primary)	If you have secondary insurance
Insured's Name:	Insured's Name:
Insured's Employer:	Insured's Employer:
Insurance Company:	Insurance Company:
Phone #:	Phone #:
DOB:	DOB:
SS#:	SS#:
Group #:	Group #:
ID number#:	ID number#:

Patient's Signature (Parent if a minor)

Date



IntegrativeDental OF DENVER

Name _____

Primary care Physician _____

Have you ever been hospitalized? _____

Have you ever had a major surgery? _____

Do you use tobacco? If so how often? _____

Do you take controlled substances? _____

Do you need to pre-medicate? _____

Do you snore? _____

Have you ever been diagnosed with sleep apnea? _____

Do you have jaw joint pain, grinding or clenching your teeth? _____

Have you ever had a serious head or neck injury? _____

Are you allergic to any of the following?

Aspirin	Acrylic	Local Anesthetics
Penicillin	Metal	Other: _____
Codeine	Latex	_____

Have you ever taken the following medications?

Actonel	Aredia	Bisphosphonates
Fosamax	Reclast	Phen-Fen
Zometa	Boniva	Redux

Women:

Are you Pregnant/Trying to get pregnant? _____

Taking oral contraceptives? _____

Nursing? _____

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

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	<input type="radio"/>	<input type="radio"/>	Hemophilia	<input type="radio"/>	<input type="radio"/>	Renal Dialysis	<input type="radio"/>	<input type="radio"/>	Alzheimer's Disease	<input type="radio"/>	<input type="radio"/>
Hepatitis A	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Anaphylaxis	<input type="radio"/>	<input type="radio"/>	Drug Addiction	<input type="radio"/>	<input type="radio"/>
Hepatitis B or C	<input type="radio"/>	<input type="radio"/>	Artificial Heart Valve	<input type="radio"/>	<input type="radio"/>	Herpes	<input type="radio"/>	<input type="radio"/>	Cold Sores/Fever Blisters	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>	Excessive Bleeding	<input type="radio"/>	<input type="radio"/>	Arthritis/Gout	<input type="radio"/>	<input type="radio"/>	Epilepsy or Seizures	<input type="radio"/>	<input type="radio"/>
Sickle Cell Disease	<input type="radio"/>	<input type="radio"/>	Excessive Thirst	<input type="radio"/>	<input type="radio"/>	Artificial Joint	<input type="radio"/>	<input type="radio"/>	Hypoglycemia	<input type="radio"/>	<input type="radio"/>
Sinus Trouble	<input type="radio"/>	<input type="radio"/>	Kidney Problems	<input type="radio"/>	<input type="radio"/>	Convulsions	<input type="radio"/>	<input type="radio"/>	Irregular Heartbeat	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Blood Transfusion	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Stomach Disease	<input type="radio"/>	<input type="radio"/>
Leukemia	<input type="radio"/>	<input type="radio"/>	Frequent Headaches	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	Liver Disease	<input type="radio"/>	<input type="radio"/>
Swelling of Limbs	<input type="radio"/>	<input type="radio"/>	Breathing Problem	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Low Blood Pressure	<input type="radio"/>	<input type="radio"/>
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	Bruise Easily	<input type="radio"/>	<input type="radio"/>	Lung Disease	<input type="radio"/>	<input type="radio"/>	Radiation Treatments	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	Mitral Valve Prolapse	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	Chemotherapy	<input type="radio"/>	<input type="radio"/>
Pain in Jaw Joints	<input type="radio"/>	<input type="radio"/>	Tumors or Growths	<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	Heart Attack/Failure	<input type="radio"/>	<input type="radio"/>
Ulcers	<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Heart Murmur	<input type="radio"/>	<input type="radio"/>	Fainting Spells/Dizziness	<input type="radio"/>	<input type="radio"/>
Psychiatric Care	<input type="radio"/>	<input type="radio"/>	Heart Pace Maker	<input type="radio"/>	<input type="radio"/>	Tonsillitis	<input type="radio"/>	<input type="radio"/>	Congenital Heart Disorder	<input type="radio"/>	<input type="radio"/>

Other conditions: _____

Current medications: _____

On a scale of 1 – 10, with 10 being the highest:

How important is your dental health? _____

How would you rate your current dental health? _____

Where do you want your dental health to be? _____

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

If you could whiten your teeth for an affordable cost, would you do it?

Why did you leave your previous dentist?

If I could change my smile, I would:

- Make it more white
- Make it straighter
- Close the spaces
- Replace the black metal filling with tooth colored restorations
- Repair chipped teeth
- Replace old crowns that don't match
- Replace missing teeth
- Have a smile makeover

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.

Patient signature (Parent if child)

Date

Dentist Signature

Sleep Health Assessment

Name _____

Recently, how likely are you to doze off or fall asleep in the following situations, in contrast to simply feeling tired?

Choose a number for each situation:	No Chance of Dozing		High Chance of Dozing	
Watching TV	0	1	2	3
Sitting and reading	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Sitting inactive in a public place (a theater or meeting)	0	1	2	3
Lying down in the afternoon when circumstance permit	0	1	2	3

Select any condition you have been treated for or use:

- | | |
|---|--|
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Stroke |
| <input type="radio"/> Heart Disease | <input type="radio"/> Depression |
| <input type="radio"/> Diabetes | <input type="radio"/> Sleep Apnea |
| <input type="radio"/> Lung Disease | <input type="radio"/> Nasal Oxygen Use |
| <input type="radio"/> Insomnia | <input type="radio"/> Restless Leg Syndrome |
| <input type="radio"/> Narcolepsy | <input type="radio"/> Morning Headaches |
| <input type="radio"/> Sleeping Medication | <input type="radio"/> Pain Medication (Vicodin, OxyContin) |

Other Conditions: _____

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Patient signature (Parent if child)

Date

Dentist Signature

Team signature



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____ have read or received a copy of this office's Notice of Privacy Practices. (Copy is in black book on the table in our waiting area or on our website under "Forms")

{Please Print Name}

{Signature}

Guardian Signature

{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself. By signing this, you also allow us to release information to any referring doctor or specialist.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name}

Relationship

{Please Print Name}

Relationship

{Please Print Name}

Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-



Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Checks that are returned to our office from your financial institution are subject to a \$20.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available through CareCredit upon request and approval.

You will have to take responsibility for any fees your insurance has not covered after 60 days. Any expenses incurred in collecting a past due account will be turned over to a collection agency after 90 days which can include attorney fees.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: _____ Date: _____