© 2012 Wisconsin Dental Association
(800) 243-4675

PATIENT NUMBER

Age ____________ Date ____________________

Patient's Name ______________________________ Date of Birth ____________ ❑ Male ❑ Female
Last First Initial

If Child: Parent's Name ______________________________

How do you wish to be addressed ______________________
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street ______________________________

City ____________________ State ____ Zip ________

Business Address ______________________________

Telephone: Res. ____________ Bus. ____________

Fax ____________ Cell Phone # ____________

eMail ______________________________

Patient/Parent Employed By ______________________

Present Position ______________________________

How Long Held ______________________________

Spouse/Parent Name ______________________________

Spouse Employed By ______________________________

Present Position ______________________________

How Long Held ______________________________

Who is Responsible for this account ______________________

Drivers License No. ______________________________

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call ______________________________

Other Family Members in this Practice ______________________

______________________________

Whom may we thank for this referral ______________________

Patient/parent Social Security No. ______________________

Spouse/Parent Social Security No. ______________________

Someone to notify in case of emergency not living with you ____________

______________________________

## DENTAL INSURANCE 1ST COVERAGE

Employee Name ______________________ Date of Birth ________

Relationship to patient ______________________

Employer Name ______________________ Yrs. ________

Name of Insurance Co. ______________________

Address ______________________

______________________

Telephone ______________________

Program or policy # ______________________

Social Security No. ______________________

Union Local or Group ______________________

## DENTAL INSURANCE 2ND COVERAGE

Employee Name ______________________ Date of Birth ________

Relationship to patient ______________________

Employer Name ______________________ Yrs. ________

Name of Insurance Co. ______________________

Address ______________________

______________________

Telephone ______________________

Program or policy # ______________________

Social Security No. ______________________

Union Local or Group ______________________

**CONSENT:**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

______________________________

______________________________

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

______________________________

DATE ______________________________

Form No. T110R

# REGISTRATION

welcome

PATIENT NUMBER

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(800) 243-4675

Patient's Name ______ Last ______ First ______ Initial ______ Date of Birth

1. Purpose of initial visit ______
2. Are you aware of a problem? ______
3. How long since your last dental visit? ______
4. What was done at that time? ______
5. Previous dentist's name ______
   Address: ______ Tel. ______
6. When was the last time your teeth were cleaned? ______

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ........ YES NO
   How often: ______
8. Were dental x-rays taken? ........ YES NO
9. Have you lost any teeth or have any teeth been removed? ........ YES NO
   Why? ______
10. Have they been replaced? ........ YES NO
11. How have they been replaced?
    a. Fixed bridge ______ Age ______
    b. Removable bridge ______ Age ______
    c. Denture ______ Age ______
    d. Implant ______ Age ______
12. Are you unhappy with the replacement? ........ YES NO
    If yes, explain ______
13. Would you like to know about permanent replacements? ........ YES NO
14. Have you ever had any problems or complications with previous dental treatment? ........ YES NO
    If yes, explain: ______
15. Do you clench or grind your teeth? ........ YES NO
16. Does your jaw click or pop? ........ YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ........ YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? ........ YES NO
19. Does food get caught in your teeth? ........ YES NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? ........ YES NO
    When? ______
22. Do you experience dry mouth? ........ YES NO
23. How often do you brush your teeth? ______ When? ______
24. Do you use dental floss? ........ YES NO
    How often? ______
25. Are any of your teeth loose, tipped, shifted or chipped? ........ YES NO
26. Are you unhappy with the appearance of your teeth? ........ YES NO
27. How do you feel about your teeth in general? ______
28. Do you feel your breath is offensive at times? ........ YES NO
29. Have you ever had gum treatment or surgery? ........ YES NO
    What? ______
    Where? ______
    When? ______
30. Have you had any orthodontic work? ______
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ______
32. Do you have any questions or concerns? ........ YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______ DATE ______

DENTIST'S SIGNATURE ______ DATE ______

ANEST.

MED. ALERT

Form No. T150DH

# DENTAL HISTORY

PATIENT NUMBER

© 2012 Wisconsin Dental Association
(800) 243-4675

Patient's Name ______________________________
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1. Physician's Name ____________________
   Address ____________________
   Tel:( )
2. Are you under a physician's care? .......... YES NO
   Since when __________ Why __________
3. When was your last complete physical exam? __________
4. Are you taking any medication or substances? .......... YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) . . YES NO
6. Are you allergic to any medications or substances? (please list) .......... YES NO
7. Do you have any other allergies or hives? .......... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? .......... YES NO
9. Are you sensitive to any metals or latex? .......... YES NO
10. Are you pregnant or suspect you may be? .......... YES NO
11. Do you use any birth control medications? .......... YES NO
12. Have you ever been treated for or been told you might have heart disease? .......... YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? .......... YES NO
14. Have you ever had rheumatic fever? .......... YES NO
15. Are you aware of any heart murmurs? .......... YES NO
16. Do you have high or low blood pressure? (please circle) .......... YES NO
17. Have you ever had a serious illness or major surgery? .......... YES NO
   If so, explain __________
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? .......... YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? .YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? .......... YES NO
21. Do you have any artificial joints/prosthesis? .......... YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? .......... YES NO
23. Have you ever bled excessively after being cut or injured? .......... YES NO
24. Do you have any stomach problems? .......... YES NO
25. Do you have any kidney problems? .......... YES NO
26. Do you have any liver problems? .......... YES NO
27. Are you diabetic? .......... YES NO
28. Do you have fainting or dizzy spells? .......... YES NO
29. Do you have asthma? .......... YES NO
30. Do you have epilepsy or seizure disorders? .......... YES NO
31. Do you or have you had venereal or any sexually transmitted disease? .......... YES NO
32. Have you tested HIV positive? .......... YES NO
33. Do you have AIDS? .......... YES NO
34. Have you had or do you test positive for hepatitis? .......... YES NO
35. Do you or have you had T.B.? .......... YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? .......... YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? .......... YES NO
38. Do you habitually use controlled substances? .......... YES NO
39. Have you had psychiatric treatment? .......... YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ...... YES NO
41. Do you have any disease condition, or problem not listed? If so, explain __________
42. Is there anything else we should know about your health that we have not covered in this form?
43. Would you like to speak to the Doctor privately about any problem? .......... YES NO

## COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ____________________ DATE __________

DENTIST'S SIGNATURE ____________________ DATE __________

ANEST.

MED. ALERT

# MEDICAL HISTORY

Form No. T140MH

**Payment Policy Contract**

Patients are responsible for payment, co-payments and deductibles at time of service. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts. In the event our office is not contacted within 30 days of you receiving our last billing statement your account will be turned over to our collection agency.

In addition, I assign directly to HS Family Dental all surgical and/or medical benefits, if any, otherwise payable to me for services rendered.

I also verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief. I authorize HS Family Dental to release my complete records to my insurance company in order to process my claim and for any other physicians or medical facilities that may be pertinent and necessary to care and treatment.

_______________________________________ ____________________

PATIENT SIGNATURE DATE

HS Family Dental
11275 E Mississippi Ave. Suite 2N
Aurora, CO 80012
Phone : (303) 750-3737
Fax : (303) 751-2285

## Informed Concent Form for General Dentistry

**1. EXAMINATION AND X-RAYS:**

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

**2. CHANGES IN TREATMENT PLAN:**

I understand that, during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination—the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions to the treatment plan as necessary.

**3. DRUGS, MEDICATION, AND SEDATION:**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand this and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of any anesthetic medication or drugs that maybe given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

**4. FILLINGS:**

I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

**5. CROWNS, BRIDGES, VENEERS AND BONDING:**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. I understand that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

**6. DENTURES – COMPLETE OR PARTIAL:**

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

**7. ENDODONTIC TREATMENT (ROOT CANAL):**

I realize there is no guarantee that root canal treatment will save a tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

**8. PERIODONTAL TREATMENT:**

I understand that serious periodontal conditions causing gum inflammation and/or bone loss can lead to the loss of my teeth. I understand that treatment plans (non-surgical cleaning, gum surgery and/or extractions) may vary depending on the severity of periodontal conditions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

**9. REMOVAL OF TEETH (EXTRACTION):**

I understand that if a tooth is not savable by e.g. root canal therapy, crowns, periodontal surgery, etc., it may be recommended that the tooth be extracted. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand that the following are some risks involved in having teeth removed: pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

**10. TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ):**

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

**CONSENT**: I have read and understood the above information. Further, I understand that dentistry is not an exact science; therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance as been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.

Signature of PATIENT, PARENT or GUARDIAN: ______________________________ DATE: ____________

Print Patient Name: ______________________________ Doctor ______________________________

## Notice of Privacy Practices

Protecting Your Confidential Health Information is important to Us

**So What has Changed?**

The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information such as our computers internet phone faxes copy machines and charts

We will use and communicate your HEALTH INFORMATION only for purposes of providing your treatment obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been given your permission.

**To Provide Treatment**

We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other healthcare personnel providing you treatment.

**To Obtain Payment**

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

**To conduct Health Care Operations**

Your health information may be used during performance evaluations of our staff. It is possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification licensing or credentialing activities.

**In Patient Reminders**

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care. These communications are an important part of our philosophy of partnering with patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, telephone, or electronic reminders, such as e-mails (unless you tell us that you do not want to receive these reminders).

**Abuse or Neglect**

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we believe we are specifically required or authorized by law. We do not need your permission to report abuse or neglect.

**Public Health and National Security**

We may be required to disclose to federal officials or military authorities health information necessary to complete an investigation related to public health. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

**For Law Enforcement**

As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain purposes including under certain limited circumstances or you are a victim of a crime or in order to report a crime.

**Family, Friends and Caregivers**

We may share your information with those you tell us will be helping you with your home hygiene treatment, medications or payment. We will be sure to ask your permission first. In the case of an emergency where you are unable to tell us what you want, we will use our best judgment when sharing your information only when it will be important to those participating in providing your care.

**Patients' Rights**

Our office will make every effort to honor reasonable restriction preferences from our patients. You have the right to request restrictions.

**Confidential Communications**

You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed.

**Inspect and Copy your Health Information**

You have the right to read review and copy your health information including your complete chart, x-rays, and billing records.

**Amend your Health Information**

You have the right to ask us to update or modify your records if you believe our records are incorrect or incomplete. Your request may be denied if the information record in question was not created you our office or is not part of our records.

**Documentation of Health Information**

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than treatment, payment or health operations. This can be no more than one request in a six year period.

**Request a Paper Copy of this Notice**

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or the Secretary of Health and Human Services if you believe you r rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know your concerns or complaints in writing. We may need to charge you a reasonable fee to duplicate and assemble your copy.

**Patient Acknowledgment**

______________________________

Patient Name

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, we want to hear from you.

______________________________ ____________

Patient/Guardian- sign Date

# HS Family Dental

11275 E Mississippi Ave Suite 2N

Aurora, CO 80012

TEL: (303)750-3737

FAX: (303)751-2285

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**Appointment Cancellation Policy**

We at HS Family Dental understand that unplanned situations can come up and that you may need to cancel an appointment. If something occurs and you need to cancel, we respectfully ask that you cancel at least 24 hours in advance.

Our doctor wants to be available for your needs and the needs of all of our other patients. When a patient does not show up for a scheduled appointment or cancels the same day, another patient loses the opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy to charge for no-show appointments as well as appointments not cancelled within 24 hours. ***As of November 1, 2014 there will be a $25.00 fee if we do not receive a call to cancel an appointment at least 24 hours before the appointment.***

Thank you for being a valued patient of ours and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointment slots to better serve the needs of all our patients.

I have read and fully understand the appointment cancellation policy and fee for HS Family Dental.

________________________________ ________________

Patient/Guardian's Signature Date