EVERGREEN FAMILY DENTISTRY, P.C.

PATIENT INFORMATION

PATIENT'S NAME _____
LAST FIRST MIDDLE NICKNAME

GENDER _____ D.O.B _____

ADDRESS _____
STREET APT #

CITY STATE ZIP CODE

PHONE _____
HOME CELL WORK

EMAIL ADDRESS _____

PREFERRED CONTACT METHOD ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-Mail

OTHER FAMILY MEMBERS

NAMES	**D.O.B.**

WHO REFERRED YOU TO US _____

WHO IS RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

NAME OF SUBSCRIBER _____ EMPLOYER _____
SUBSCRIBER'S D.O.B _____ PATIENT'S RELATIONSHIP TO INSURED _____
INSURANCE CO. NAME _____
INSURED ID # or SS # _____ GROUP # _____
INSURANCE CO. MAILING ADDRESS _____
_____ PHONE # _____

SECONDARY DENTAL INSURANCE (if you have dual coverage)

NAME OF SUBSCRIBER _____ EMPLOYER _____
SUBSCRIBER'S D.O.B _____ PATIENT'S RELATIONSHIP TO INSURED _____
INSURANCE CO. NAME _____
INSURED ID # or SS # _____ GROUP # _____
INSURANCE CO. MAILING ADDRESS _____
_____ PHONE # _____

OFFICE FINANCIAL AND APPOINTMENT POLICY

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from each patient for the costs incurred in their care and 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 at the time services are rendered. There may be a service charge of 1.5% per month (18% annual) on any unpaid balances. The service charge will be posted to all accounts exceeding 60 days, unless previously written financial arrangements are discussed.

I hereby authorize the release of any dental or medical records as necessary to assist in dental treatment and/or relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes Evergreen Family Dentistry, P.C. to submit claims for benefits and services rendered or to be rendered and that I will be bound by this signature as though I had personally signed the particular claim.

Your appointment is a reservation of yours and the dentist's time to meet your needs. A 24 hour notice is required if your appointment cannot be kept. This office reserves the right to charge a broken appointment fee of $75 per 1/2 hour of scheduled time if the appointment is not kept.

Signature of patient, parent or guardian Date

Relationship to patient

HEALTH HISTORY

PATIENT'S NAME _____
LAST FIRST MIDDLE NICKNAME

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____

PHYSICIAN'S PHONE _____

IN CASE OF EMERGENCY, NOTIFY _____ PHONE _____

Answers to the following questions are for our records and will be considered confidential.

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY.

- ☐ A.I.D.S./H.I.V Positive
- ☐ Alcohol Abuse
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Artificial Joints (hip, knee, etc.)
  _____
  _____
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bone Grafts
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Cough
- ☐ Circulatory Problems
- ☐ Cold Sores/Fever Blisters
- ☐ Cortisone Medicine
- ☐ Cosmetic Surgery
- ☐ Diabetes
  Diet - Restricted Y
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Dry Mouth
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Goiter
- ☐ Hard of Hearing
- ☐ Wear Hearing Aids
- ☐ Hay Fever
- ☐ Head Aches - How often
  _____
- ☐ Head Injuries
  _____
- ☐ Hemophilia
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis C
- ☐ Herpes
- ☐ Implants - where?
  Dental _____
  Other _____
- ☐ Jaundice
- ☐ Kidney Disease/Problems
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Neurological Disorders
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Psychiatric - Psychological Care
- ☐ Radiation Therapy
- ☐ Head/Neck Injury
  Date: _____
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Sinus or Nasal Problems
- ☐ Skin Rash
- ☐ Staph Infections
- ☐ MERSA
- ☐ Stomach Problems
- ☐ Swollen Ankles
- ☐ Thyroid Disease
- ☐ Tobacco Use - how long?
  Cigarette _____
  Chew _____
  Pipe _____
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

HEART

- ☐ Angina
- ☐ Artificial Heart Valve
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Stroke

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO ANY OF THE FOLLOWING?

- ☐ Aspirin
- ☐ Chemicals
- ☐ Codeine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Jewelry - Rash or Sensitivity
- ☐ Latex or Rubber Products
- ☐ Metal of any kind
- ☐ Penicillin
- ☐ Sedatives, Barbiturates
- ☐ Sulfa Drugs/Sulfites/Sulfides
- ☐ Tetracycline
- ☐ Food Products (gluten) _____
- ☐ Local Anesthesia (Novocain, etc.) _____
- ☐ Other Antibiotics _____
- ☐ Other allergies or reactions _____
- ☐ Other Pain Meds _____

FOR WOMEN ONLY

Are you Pregnant, or is there any chance you might be Pregnant? _____

Are you nursing? _____ Are you taking pre-natal vitamins? _____ Do you use prescription birth control? _____

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

HEALTH HISTORY

Are you under the care of a physician? _____ If yes, please explain _____

Do you have any health problems that need further clarification? _____ If yes, please explain _____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS
Please check those that apply.

- ☐ Antibiotics _____
- ☐ Anticoagulants (Blood Thinners) _____
- ☐ Aspirin or drugs such as Motrin, Aleve, Ibuprofen _____
- ☐ Digitalis, Inderal, Nitroglycerin or other heart drug _____
- ☐ Diet Drugs Taken: Fen-Phen, Redux _____
- ☐ High Blood Pressure medications _____
- ☐ Insulin or Oral Anti-Diabetic drugs _____
- ☐ Steroids (Cortisone, etc) _____
- ☐ Tranquilizers _____

Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers? ☐ Yes ☐ No
(please circle) Actonel Aredia Boniva Didronel Fosamax Reclast Skelif Zometa
How long have you been on bisphosphonate therapy? _____
Any episodes of osteonecrosis? ☐ Yes ☐ No If yes, explain _____

Please list any other medications taken, including prescription medications, over-the counter medications, herbal or holistic remedies, vitamins or minerals: _____

Have you ever been advised not to take a medication? ☐ Yes ☐ No If yes, explain _____

Any disease, drug or transplant operation that has depressed your immune system? ☐ Yes ☐ No If yes, explain _____

Do you have any other conditions, diseases, or problems not listed above? □ Yes □ No If yes, explain _____

CONSENT OF SERVICES

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor and the information I have provided here is complete and accurate.

I understand that this information will be used by the dentist and staff to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform the dentist. Since at each visit a plan of treatment will be presented and the work to be done explained to me, along with any risks, before treatment has begun I give Dr. Fox and his staff my consent to perform any needed dental treatment on myself or my child/dependent.

Signature of patient, parent or guardian Date

Signature of doctor/hygienist Date

DENTAL HISTORY

What is the reason for your visit today? _____
Date of last dental visit _____ Date of last dental cleaning _____
Last full mouth set of x-rays _____ Last Bite-wing x-rays _____
Previous dentist's name _____ Phone _____
How often do you see a dentist? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? Please circle: Toothpicks Softpiks Flosspiks Sonicare Oral-B Spinbrush
RX Strength toothpaste MI Paste Mouthwash Other: _____
Do you have any current dental problems? _____ If yes, please explain _____

Do you feel nervous about having dental treatment?____If yes, what is your concern?_____

Have you ever had a negative dental experience?_____ If yes, please explain _____

Answers to the following questions are for our records and will be considered confidential.
DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY.

- ☐ Are your teeth sensitive to Hot or Cold
- ☐ Are your teeth sensitive to Sweets
- ☐ Are your teeth sensitive to Biting or Chewing
- ☐ Have you noticed any mouth odors
- ☐ Have you noticed any bad tastes
- ☐ Has anyone told you - you have mouth odor
- ☐ Frequently get cold sores
- ☐ Frequently get blisters
- ☐ Frequently get any other oral lesions
- ☐ Have you had dry mouth
- ☐ Do your gums bleed or hurt
- ☐ Have your parents experienced gum disease
- ☐ Have you had any tooth loss
- ☐ Have you noticed any loose teeth
- ☐ Does food tend to become caught between your teeth
  Where?
- ☐ Bite your lips or cheeks regularly
- ☐ Hold objects with your teeth (pencils, pipe, pins, nails etc)
- ☐ Mouth breathe while you sleep
- ☐ Snore
- ☐ Sleeping Disorders
- ☐ Smoke/chew tobacco or use other tobacco products
- ☐ Orthodontic treatment
- ☐ Dental oral surgery
- ☐ Periodontal treatment - deep cleaning
- ☐ Periodontal Surgery
- ☐ Teeth ground or the bite adjusted
- ☐ Worn a bite plate, night guard or mouth guard
- ☐ Clicking or popping of the jaw
- ☐ A serious injury to the mouth or head
  Please describe _____
- ☐ Clench or grind your teeth while awake or asleep
- ☐ Pain in your joints, ear or side of face
- ☐ Difficulty in opening or closing your mouth
- ☐ Difficulty in chewing on either side of your mouth
- ☐ Tired jaws, especially in the morning
- ☐ Headaches, neck aches or shoulder aches
- ☐ Sore muscles (neck, shoulders)
- ☐ Are you satisfied with your teeth's appearance
- ☐ Would you like to keep all of your teeth all of your life
- ☐ Are you interested in Whitening your teeth

CHILDREN

Has your child complained about dental problems?_____ If yes, please explain _____

Does your child brush his/her teeth daily? _____
Does your child floss his/her teeth everyday?_____
Does your child take fluoride in any form? _____
Any mouth habits: thumb sucking nail biting mouth breathing pacifier sleeping with bottle
Other?_____

GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction**. Dental materials and medication may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia)**. Local anesthetic, or its administration, while almost always adequate to allow for comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness**. Holding one's mouth open, and dental injections, can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding**.
5. **Swallowing or inhaling small objects**.

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statements on this page.

Signature of patient, parent or guardian Date

Relationship to patient

EVERGREEN FAMILY DENTISTRY, P.C.
TROY A. FOX, D.D.S.
3720 Evergreen Parkway - P.O. Box 3958 - Evergreen, CO 80437-3958
Phone: 303.674.3591 Fax: 303.674.9650

PATIENT HIPPA FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- □ Treament (including direct or indirect treatment by other healthcare providers involved in my treatment)
- □ Obtain payment from third-party payers (i.e. my insurance company)
- □ The day-to-day healthcare operations of practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time-to-time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____, 20____

_____
Patient's Name (please print)

_____
Signature of patient, legal guardian or
authorized legal guardian