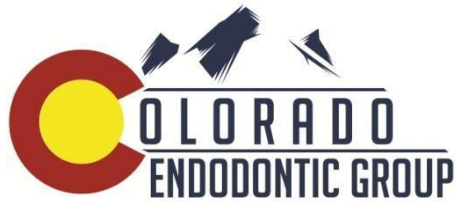


Patient Information

Name: ____
Last First Middle

Referring Dentist: ____

E-Mail Address: ____ Gender: Male________Female______

Cell Phone: (____)_____________ Home Phone: (____)_____________ Work Phone: (____)_____________

Home Address:____
Street City State Zip

Date of Birth: ___/___/______ Social Security Number: _____-____-______ Driver's License or ID Number:______________________
MM / DD / YYYY

Responsible Party Information (If Patient is a Dependent)

Name: ____
Last First Middle

Relationship to Patient: _________________________ E-Mail Address: ______________________________________

Cell Phone: (____)_____________ Home Phone: (____)_____________ Work Phone: (____)_____________

Home Address:____
Street City State Zip

Date of Birth: _____/___/______ Social Security Number: _____-____-______ Driver's License or ID Number:______________________
MM / DD / YYYY

Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: ____
Last First Middle

Primary Policy Holder's Date of Birth: _____/___/______ Primary Policy Holder's SS/ Member ID Number: ____-____-______
MM / DD / YYYY

Primary Policy Holder's Employer:____

Insurance Company Name:____________________ Group Number:_____________ Insurance Company Phone: (____)___________

Insurance Company Address:____
Street City State Zip

Emergency Contact Information

Local Friend or Relative not Living With You: ______________________________ Emergency Contact Phone: (____)_____________

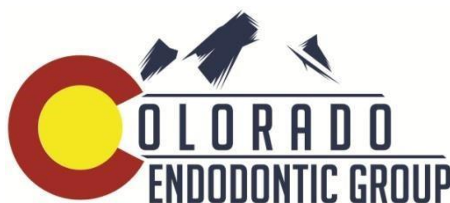
Emergency Contact Address:____
Street City State Zip

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

____

SIGNATURE OF RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT** **DATE**



MEDICAL HISTORY – Please Answer ALL Questions

Name:____ **Date of Birth:**__________________

Gender: Male / Female

Primary Care Physician:____ **Phone/Contact:**___________________

1. Do you consider yourself a healthy person? ………………………………………………………………❑ Yes ❑ No
2. Have you been under the care of a medical doctor during the past two years? …………………………❑ Yes ❑ No

   If yes, for what reason?__________________________________ Est. Last Physical Exam Date:_____________
3. Do you consider your teeth, gums and mouth to be healthy and problem free? ……………..…………❑ Yes ❑ No
4. Do your gums bleed at any time? .... ❑ Yes ❑ No
5. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or

   made sick by penicillin, aspirin, codeine, or any drugs or medications? .... ❑ Yes ❑ No

   If yes, please list.____
6. Have you ever had excessive bleeding requiring special treatment? ……………………………….…❑ Yes ❑ No 7.

   Women: Are you or might you be pregnant? …………. ❑ Yes ❑ No Estimated Due Date___________________
8. Check any and all of the following which you have a history of or currently under treatment for:

   ❑ Heart Disease or Attack ❑ Ulcers ❑ HIV Positive (AIDS)

   ❑ Tuberculosis (TB) ❑ Shortness of Breath ❑ Cancer or Tumor

   ❑ Asthma ❑ Hepatitis (circle: Type A, B or C) ❑ High Blood Pressure

   ❑ Rheumatic Fever ❑ Liver Disease ❑ Heart Murmur/Mitral Valve

   ❑ Scarlet Fever ❑ Diabetes ❑ Bruise Easily

   ❑ Artificial Heart Valve ❑ Thyroid Disease ❑ Drug Addiction

   ❑ Heart Pacemaker ❑ Chemotherapy (Cancer, Leukemia) ❑ Hemophilia

   ❑ Heart Surgery ❑ Arthritis ❑ Cold Sores or Fever Blisters

   ❑ Artificial Joint ❑ Cortisone Medication ❑ Epilepsy or Seizures

   ❑ Stroke ❑ Glaucoma ❑ Nervousness

   ❑ Kidney Trouble ❑ Pain in Jaw Joints ❑ Psychiatric Treatment

Do you have or have history of any surgery, disease or medical condition not listed on this form? ....❑ Yes ❑ No

Please list:____

____

9. List all Prescription Medications you are taking at this time. ❑ None ____

____

10. Do you use any type of tobacco product regularly? .... ❑ Yes ❑ No

11. Do you use or have you ever used recreational drugs?... ❑ Yes ❑ No

Signature: ____ **Date:** ____________________________

Updates (date & initial) ________ ________ ________ ________ ________ ________ ________

DENTAL INSURANCE POLICY

Colorado Endodontic Group proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

-------------------------------------PATIENT ACKNOWLEDGMENT AND AUTHORIZATION--

I understand and agree to Colorado Endodontic Group Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Colorado Endodontic Group. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: ____ Date: _________________

CANCELLATION POLICY

Colorado Endodontic Group makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 48 hours notice if you are unable to keep your scheduled appointment**. **We reserve the right to charge a cancellation fee of $50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: ____ Date: ________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, ____, have had the opportunity to review Colorado Endodontic Group Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: ____ Date: ________________