Patient Number ____________

Date ____________

WELCOME

Thank you for choosing Stratton Family Dental! We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

SS#/SIN ____________

Name ____________ Birthdate ____________

Address ____________

E-Mail ____________ Phone ____________

Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College ____________ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer ____________ Work Phone ____________

Business Address ____________

Spouse or Parent/ Guardian's Name ____________ Employer ____________ Work Phone ____________

Emergency Contact ____________ Phone ____________

Whom may we thank for referring you? ____________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ____________ Relationship to Patient ____________

Address ____________

E-Mail ____________ Phone ____________

Driver's License # ____________ Birthdate ____________ Financial Institution ____________

Employer ____________ Work Phone ____________ SS#/SIN ____________

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full due at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MASTERCARD ☐ I wish to discuss the office's payment policy.

INSURANCE INFORMATION

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ SS#/SIN ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Address of Employer ____________

Insurance Company ____________ Group # ____________ Policy ID# ____________

Insurance Co. Address ____________

How much is your dedictible? ____________ How much have you used? ____________ Max annual benefit? ____________

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ SS#/SIN ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Address of Employer ____________

Insurance Company ____________ Group # ____________ Policy ID# ____________

Insurance Co. Address ____________

How much is your dedictible? ____________ How much have you used? ____________ Max annual benefit? ____________

PATIENT MEDICAL HISTORY

Physician________________ **Office Phone** ________________ **Date of Last Exam** __________

Address ________________________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain:	☐	☐

____

____

	Yes	No
3. Are you taking any medications? (Including non-prescription medicine.) If yes, please list medication(s)	☐	☐

____

____

	Yes	No
4. Have you ever taken Fen/Phen Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)........	☐	☐
Penicillin or any other Antibiotics........	☐	☐
Sulfa Drugs...	☐	☐
Barbiturates...	☐	☐
Sedatives...	☐	☐
Iodine..	☐	☐
Aspirin...	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber..	☐	☐
Other (please list)		

____

	Yes	No
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only		
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐

	Yes	No
High Blood Pressure..............	☐	☐
Heart Attack...........................	☐	☐
Rheumatic Fever....................	☐	☐
Swollen Ankles.......................	☐	☐
Fainting/Seizures...................	☐	☐
Asthma..................................	☐	☐
Low Blood Pressure..............	☐	☐
Epilepsy/Convulsions............	☐	☐
Leukemia...............................	☐	☐
Diabetes................................	☐	☐
Kidney Disease.......................	☐	☐
AIDS or HIV Infection.............	☐	☐
Thyroid Problem....................	☐	☐

	Yes	No
Heart Disease.........................	☐	☐
Cardiac Pacemaker................	☐	☐
Heart Murmur........................	☐	☐
Angina....................................	☐	☐
Frequently Tired....................	☐	☐
Anemia...................................	☐	☐
Emphysema...........................	☐	☐
Cancer....................................	☐	☐
Arthritis..................................	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis/Jaundice..................	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers.......	☐	☐

	Yes	No
Chest Pains............................	☐	☐
Easily Winded.........................	☐	☐
Stroke.....................................	☐	☐
Hay Fever/Allergies...............	☐	☐
Tuberculosis...........................	☐	☐
Radiation Therapy.................	☐	☐
Glaucoma...............................	☐	☐
Recent Weight Loss...............	☐	☐
Liver Disease..........................	☐	☐
Heart Trouble........................	☐	☐
Respiratory Problems...........	☐	☐
Mitral Value Prolapse............	☐	☐
Other __________		

PATIENT DENTAL HISTORY

Name of Previous Denist and Location ____________________ **Date of Last Exam** __________

	Yes	No
1. Do your gums bleed while flossing?	☐	☐
2. Are your teeth sensitive to cold liquids/food?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/ foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking..	☐	☐
Pain (joint, ear, side of face).........	☐	☐
Difficulty in opening or closing.....	☐	☐
Difficulty in chewing.....................	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had a difficult extraction?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you have any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, placement __________	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits or otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

X ________________________________

Signature of patient (or parent/legal guardian if minor) Date

Doctor's Comments ____________________

Signature Date

Patient Consent & Authorization Release of Protected Health Information

Name ______________________ **Birthdate** ______________

Address ______________________

E-Mail ______________________ **Phone** ______________

PATIENT AUTHORIZATION

I, ______________________ , hereby authorize the release, use, or disclosure of my health information as follows.

This authorization pertains to the following type of medical information about me:

____

____

I hereby authorize Stratton Family Dental to release the above described information to:

____
Name of individual(s) and/or organization providing information

I understand that per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountibility Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to Stratton Family Dental.

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on ______________
Expiration date or event

If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

PATIENT MEDICAL HISTORY

Signature ______________________ **Date** ______________

Name ______________________
Please Print

Relationship to Patient ______________________

FOR OFFICE USE ONLY

Reveived by: ______________________ **Date** ______________

Blake Cure, DDS & Annette Isenbart, RDH
317 Colorado Avenue
Stratton, CO 80836
(719) 348-5610

FINANCIAL POLICY

We are committed to providing you with the best possible dental care. Payment is due at the time services are rendered. We accept cash, checks, Master Card, Discover, and Visa. As an additional option, we offer Care Credit, a finance plan for patients who qualify.

An Interest charge of 1.5% per month will be charged on any unpaid balance over sixty (60) days old.

If you have insurance, we will be happy to help you process your insurance claim. Assignment of benefits must be made to us, unless you make payment in full on the day of service. We are eager to help you receive your maximum allowable benefits. All deductibles and co-payments are due at the time services are rendered. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract

- Most insurance companies consider our fees usual, customary, and reasonable. This does not apply to insurance companies who reimburse based on fixed-fee schedule, which bears no relationship to the current standard and cost of care in this area.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

If we have not received payment from the insurance company within fifty (50) days of the original filing, the patient will be responsible for the entire account.

We must emphasize that, as dental care providers, our relationship is with you - not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility.

Any and all costs of collection, including but not limited to attorney's fees, will be the patient's responsibility. A $30 fee will be charged for each check returned for insufficient funds. Bad checks may be referred to the District of Attorney for prosecution.

We reserve the right to charge a fee of $50 for appointments cancelled or broken without 48 hours notice

Signature ______________________________ **Date** ______________

Blake Cure, DDS & Annette Isenbart, RDH
317 Colorado Avenue
Stratton, CO 80836
(719) 348-5610

ACKNOWLEDGMENT FOR DENTAL EXAMINATION

This will serve to acknowledge my Dental Examination is completed by Blake Cure, DDS or Annette Isenbart, RDH. By signature, I acknowledge and approve that any diagnosis or assessment is for the purpose of determining necessary dental hygiene services only. It is recommended by the American Dental Association, or any successor organizations, that a thorough dental examination be performed by a dentist twice a year.

______________________________ Patient Name (Print)

______________________________ Person Authorized to Sign for Patient

______________________________ Patient Signature

______________________________ Date