Greenwood Springs
Family Dental Care

Welcome to Greenwood Springs Family Dental Care - Tell us about yourself

Name: _____
Last First MI Title

Preferred Name:_____ □ Male □ Female

Address: _____

SSN:_____ Date of Birth: _____

Home Phone:_____ Work Phone: _____

Cell Phone:_____ E-mail Address: _____

Employer:_____ Occupation: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Domestic Partner

How did you hear about our office? _____

Insurance - Primary

Subscriber Name: _____ Relationship to Patient: _____

Subscriber SSN/ID: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance - Secondary

Subscriber Name: _____ Relationship to Patient: _____

Subscriber SSN/ID: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and assign directly to Greenwood Springs Family Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance admissions.

Responsible Party Signature: _____

Relationship:_____ Date: _____

Medical History

Do you have a personal physician? □ Yes □ No
Physicians name: _____
Physicians phone number:_____
Date of last visit: _____
Your current health is: □ Good □ Fair □ Poor
Are you currently under the care of a physician? □ Yes □ No
Please explain:_____
Do you use tobacco products in any form? □ Yes □ No How often? _____
Have you had any metal rods, pins, or implants placed? □ Yes □No
Are you taking any medications? □ Yes □ No
Please list each one: _____
Have you ever had any surgical problems? □ Yes □ No
Please list each one: _____

Yes	Conditions
□	Abnormal Bleeding
□	Alcohol Abuse
□	Allergies
□	Anemia
□	Angina Pectoris
□	Arthritis
□	Artificial Heart Valve
□	Asthma
□	Blood Transfusion
□	Cancer
□	Chemotherapy
□	Colitis
□	Congenital Heart Defect
□	Diabetes
□	Difficulty Breathing
□	Drug Abuse
□	Emphysema
□	Epilepsy
□	Facial Surgery
□	Fainting Spells
□	Fever Blisters
□	Frequent Headaches

Yes	Conditions
□	Glaucoma
□	HIV & AIDS
□	Heart Attack
□	Heart Murmur
□	Heart Surgery
□	Hemophilia
□	Hepatitis A
□	Hepatitis B
□	Hepatitis C
□	High Blood Pressure
□	Joint Replacement
□	Kidney Problems
□	Liver Disease
□	Low Blood Pressure
□	Mitral Valve Prolapse
□	Pace Maker
□	Psychiatric Problems
□	Radiation Therapy
□	Rheumatic Fever
□	Seizures
□	Sexually Transmitted Disease
□	Shingles

Yes	Conditions
□	Sickle Cell Disease
□	Sinus Problems
□	Stroke
□	Thyroid Problems
□	Tuberculosis
□	Ulcers

Yes	Allergies
□	Aspirin
□	Codeine
□	Dental Anesthetics
□	Erythromycin
□	Jewelry
□	Latex
□	Metals
□	Penicillin
□	Tetracycline

Yes If Female Please Answer
□ Are you taking birth control pills?
□ Are you pregnant? If so how many weeks___
□ Are you nursing?

Nearest relative not living with you:
Name: _____ Relationship: _____
Address: _____Phone Number:_____
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status.
Signature: _____ Date: _____

Handle Me with Care

Please check the box next to the statement that concerns you or describes your situation best:

- □ I gag easily
- □ I feel out of control when I am lying down in a dental chair.
- □ I have not been to the dentist in a long time and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
- □ Pain relief is top priority for me.
- □ I do not like shots / I have a bad reaction to shots.
- □ Please tell me what I need to know about my mouth so that I can make an informed decision.
- □ My teeth are very sensitive.
- □ I do not like the sound of that tool that makes the picking and scraping noise.
- □ I do not like cotton in my mouth.
- □ I hate the noise of the drill.
- □ Please respect my time. I do not want to sit in the reception area for an extended period of time.
- □ I want to know all costs up front.
- □ I have difficulties listening and remembering what I hear while sitting in the dental chair.
- □ I have health problems and questions that we need to discuss.

Handle Me with Care Partnership Pact:

I ask that you honestly inform me of all my dental problems. I want to be made aware of the highest quality of dentistry available today. I would like to discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me in your dental office, how each dental procedure will work, and how much of my time will be required.

Patients Signature *Date*

Dental History

How may we help you today? _____

Your current dental health is: □ Good □ Fair □ Poor

Do you require antibiotics before dental treatment? □ Yes □ No

Are you currently in pain? □ Yes □ No

Have you ever had gum treatment? □ Yes □ No

Do you now, or have you had any pain/discomfort in your jaw joint? (TMJ) □ Yes □ No

Are you under any stress? (new job, moving, relationship) □ Yes □ No

Do you like your smile? □ Yes □ No

Is there anything you would like to change about your smile? □ Yes □ No

Are you happy with the color of your teeth? □ Yes □ No

How many times do you: floss/week?_____ brush/week?_____

Are your teeth sensitive to heat, cold or anything else? □ Yes □ No

Have you lost any teeth? □ Yes □ No

Have you ever had a serious/difficult problem with any previous dental work? □ Yes □ No

Have you ever had any unfavorable dental experience? □ Yes □ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Greenwood Springs Family Dental Care we offer a wide range of services to enhance your smile and keep it beautiful. Please circle any services below that you would like our friendly staff to discuss with you during your visit.

Teeth Whitening

Traditional Orthodontics (Brackets)

Sealants

Partials/Dentures

Veneers/Lumineers

Smile Makeover

Crown/Bridge

Night/Sports Guards

Six Months Smiles

Bonding

Implant Crowns

Acknowledgement of receipt of notice of privacy practices

I,_____, have received a copy of this office's notice of privacy practices.

_____	_____	_____
Print Name	*Signature*	*Date*

For office use only

- □ Individual refuses to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (please specify)

_____
_____
_____
_____
_____

Insurance and Financial Policy

At Greenwood Springs Family Dental Care, we believe that you deserve the best care; that's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know.

Initial

_____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

_____ We currently accept all private care insurance plans (that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefits we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you exact out of pocket figures you may require.

_____ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Greenwood Springs Family Dental Care reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be a part of the legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ Greenwood Springs Family Dental Care does require payment in full for your portion at the time of service. We accept Master Card, Visa, American Express, Discover, cash and checks. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, 12, or 18 months "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment we require at least 24 hours notice.

I agree with the above conditions.

Print Name:_____ Date: _____

Patient/Parent Signature: _____