



## Patient Registration

Patient Name First \_\_\_\_\_ Initial \_\_\_\_\_ Last \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell or Work Number \_\_\_\_\_

E-mail address \_\_\_\_\_

**Would you like to be notified of your appointments by: Email / Text / Phone / Postcard**

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(Circle) Male Female Referred By: \_\_\_\_\_

Responsible Party Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security Number \_\_\_\_\_

Phone # \_\_\_\_\_ Cell/Work # \_\_\_\_\_

Employer Address \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Phone Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Phone Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Group Number \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

**Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with the above mentioned insurance company and assign directly to Boulder Dental Group 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 understand that payment is due at the time of treatment. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. I authorize the use of my signature on all insurance submissions. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

**HIPPA**

The above named dentist may use my health care information or minor/child's information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I have been given the "notice of privacy practices" brochure, read and understand that it covers federal law pertaining to privacy practices. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature for Assignment and Release and HIPPA \_\_\_\_\_ Date \_\_\_\_\_

**MINOR/CHILD CONSENT**

I am the parent, guardian, or personal representative of \_\_\_\_\_. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, administration of anesthetics and dental treatment which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Signature for Minor/Child Consent \_\_\_\_\_ Date \_\_\_\_\_



Office Use Only:

BP: \_\_\_\_\_

ASA: \_\_\_\_\_

Allergies: \_\_\_\_\_

CC: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical Health History

**Do you have or have you had any of the following:  
(Please circle all that apply)**

Artificial Joints ( e.g.,Knee, Shoulder, Pins,Implants)

Fainting Spells, Seizures or Epilepsy

Abnormal bleeding

Persistent cough or swollen glands

Diabetes Type I/ Type II

Heart problems/Surgery

Lung problems

Liver or Kidney Problems

Diabetes

High / Low Blood Pressure

Pacemaker

Stroke

Cancer/Tumor

Location/Type:

\_\_\_\_\_

None Of the Above Apply: \_\_\_\_\_

Premedications required by physician:

\_\_\_\_\_

**List Other :**

\_\_\_\_\_

**Are you allergic, or have you reacted adversely, to any of the following:**

Local anesthetics ("Novocaine")

Sulfa drugs, Aspirin

Codeine

Latex

None

Penicillin or other antibiotics

acetaminophen or Ibuprofen

Reaction to Metals

Other: \_\_\_\_\_

**During the past 12 months, have you taken any of the following:**

Anticoagulants (e.g., Coumadin)

Insulin or similar drug

High blood pressure medication

Digitalis or drugs for heart trouble

**Please list all current medication, amount, and why you are taking:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Women ONLY:**

Are you pregnant? Y/N If so, expected delivery date: \_\_\_\_\_  
Are you on birth control? Y/N  
Are you nursing? Y/N

**Dental Health History:**

What is the reason for your visit today? \_\_\_\_\_

Do you have difficulty in chewing your food? Y/N

Do you have Dry Mouth? Y/N

Do you avoid brushing any part of your mouth? Y/N

Do you wear partials/dentures? Y/N

Do your gums bleed easily? Y/N

Are your teeth sensitive? Y/N

**Do you feel pain with:**

Hot or cold foods or liquids? Y/N Sweet or sour? Y/N Pressure? Y/N

**We recommend you brush twice daily and floss once per day.** \_\_\_\_\_  
(Initial that you acknowledge)

**Are you interested in a bite guard for night, day or sports?** Y/N

**Dental History:** Please circle what best describes your past dental problems and care:

Regular Dental Care                      Occasional Dental Care

Gum disease (gingivitis or periodontal disease)

**Have you had any adverse reaction to dental treatment? Please describe.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **Billing and Insurance Policy**

Boulder Dental Group has several options to enable you to receive your proper dental care. All fees are to be paid at the time services are rendered. As a convenience to our patients with dental insurance, our office will submit the required information for payment. We accept most insurance plans. Many insurance companies will not cover 100% of all dental expenses. Your portion not covered by insurance will be due at the time services are rendered. The patient is still the responsible party regarding all dental fees. We will do our best to approximate the patient portion, but please keep in mind that these figures are estimates and true portion amounts will not be determined until final payment is received. Please understand that dental insurance is a contract between the patient and the insurance carrier, not the carrier and the dentist.

We want your visit to be a pleasant experience. We will do everything to make sure that all fees for service are billed efficiently and in a timely manner to ensure proper handling of your account. We thank you for your confidence in choosing our office for all your dental needs.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Cancellation and No-show Policy

**Cancellation of an Appointment:** In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment. Your time will be given to someone who is in urgent need of treatment. **Any appointment(s) not cancelled 48 hours in advance will be subject to a \$50 cancellation fee.**

**No-show Policy:** A no-show is an appointment that was not cancelled in advance. No-shows inconvenience other patients who need dental care and can cost the practice a lot of money by having the doctor and staff idle. This ultimately increases costs for everyone. **A no-show for a scheduled appointment will therefore result in a fee of \$50 for every hour of scheduled appointment time.**

We try to respect each patient's time and we ask the same from you. Because we will not compromise the service and quality of patient care, we need to address the cancellation issue head-on. This includes scheduled time with Doctor Huxford, the hygienists and appointments with the assistants.

Boulder Dental Group goes to great lengths to provide courtesy reminders for appointments. We don't want you to forget about your appointment, but once you've scheduled with us, the responsibility is still yours to keep the appointment or cancel within the allotted time frame.

We appreciate all of our patients. Our focus will remain the same: Provide outstanding patient care at affordable prices, which is only possible when patients help do their part as well.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_