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 responsiblilty 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 _____

boulder dental group

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 sours? 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: _____