INDIAN PEAKS DENTAL

Date: _____

Name: _____

Birthday: _____

Patient Information

Social Security Number: _____

Referred By: _____

Home Phone: _____

Mobile Phone: _____

Email: _____

Address: _____

City: _____

State: _____ Zip: _____

Dental Insurance

Company:_____

ID Number:_____

Group Number: _____

Subscriber Information (if not the patient):

Subscriber Name: _____

Subscriber Date Of Birth:_____

Medications:

Pharmacy Name: _____

Have you ever used a bisphosphonate medication? Common brand names of Fosamax, Actonel, Atelvia, Didronel, Boniva.
☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

List any medications that you are currently taking:

_____

_____

Allergies:

_____

_____

_____

Dental/Health History

Patient Name: _____

Previous Dentist: _____

Reason for today's visit: _____

Date of most recent dental visit: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No	Bleeding gums	☐ Yes ☐ No
Sensitivity to cold	☐ Yes ☐ No	Blisters on lips or mouth	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
Sensitivity to sweets	☐ Yes ☐ No	Burning sensation on tongue	☐ Yes ☐ No	Chew on one side of mouth	☐ Yes ☐ No
Smoking	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No	Sores/growths in mouth	☐ Yes ☐ No
Pain around ear	☐ Yes ☐ No	Clicking or popping jaw	☐ Yes ☐ No	Dry mouth	☐ Yes ☐ No
Mouth pain, brushing	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No	Fingernail biting	☐ Yes ☐ No
Mouth Breathing	☐ Yes ☐ No	Foreign objects	☐ Yes ☐ No	Broken fillings	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No	Loose teeth	☐ Yes ☐ No	Gums swollen or tender	☐ Yes ☐ No
Lip or cheek biting	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No		
Food collection between teeth	☐ Yes ☐ No				

How often do you floss? _____ How often do you brush? _____

Physician's Name: _____ Date of last visit: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Arthritis, Rheumatism	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No		
Blood Disease	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No	Cortisone Treatment	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Scarlet Fever	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Circulatory Problems	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Swollen Feet/Ankles	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No	Cough, persistent or bloody	☐ Yes ☐ No	Tumor or growth on head/neck	☐ Yes ☐ N
Bleeding abnormally	☐ Yes ☐ No				

*with extractions/surgery

Women:

Are you pregnant? ☐ Yes ☐ No

Due date _____

Taking birth control pills? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

Date: _____

Signature:

_____

Printed Name:

_____

Relationship to Patient (if other than patient):

_____

INDIAN PEAKS DENTAL

1319 W Baseline Road
Suite 200
Lafayette CO, 80026
303-664-5775

Financial and Appointment Agreement

Financial Options Include

- Cash, Check, or Credit Card
- Dental Insurance
    - In order to prevent any misunderstandings about dental insurance, we wish to point out that: **Your insurance coverage is a contract between you and your insurance company. It is not possible for us to provide services on the basis that your insurance will pay all charges because plans vary greatly.** Your insurance company may or may not cover any or all of your charges. Our fees are considered usual and customary, but the insurance company may deny payment based on any number of reasons. Please be aware that checking your insurance benefits is a ***complimentary service*** that our office performs. It is ultimately ***your responsibility to know your dental insurance coverage.***

      I, the patient, understand that dental insurance:

        - **Does not pay for all of my fees and I alone am responsible**
        - It **may** have **limitations**
        - It **may** have **limitations on the total amount** of my coverage. Typically, between $700-$1500 per calendar year
        - It is **likely** that the insurance company will downgrade resin to silver/amalgam restorations and/or crowns and will reimburse me at a much decreased dollar amount.

I understand that I am ***ultimately responsible for payment of all services*** rendered.

I understand that accounts more than 30 days ***past due will accrue interest*** of 1.5% per month or 18% per annum.

_____ _____

Patient or Patient Guardian Signature Date

Appointment Reservation

When you schedule an appointment, we reserve a specific time **for you.** If you fail to show or you cancel with short notice, we cannot offer that time to another patient. If you have to reschedule an appointment, please notify our office as early as possible. **A courtesy 48-hour advance notice** will give us time to offer your appointment to another patient. If leaving a voice mail, please take into consideration we only answer it during our normal business hours. A broken appointment or late cancellation **fee of $50.00** will be applied to your account.

_____ _____

Patient or Patient Guardian Signature Date

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Informed Consent

I authorize Dr. Cara Jones, DDS and dental auxiliaries as she may designate to perform procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or dependent, including arrangement and/or administration of any anesthesia, analgesic and anxiolysis and also including procedures related to restorative, palliative, therapeutic or surgical treatment.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that very rarely, needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings and crowns, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, etc. may be aspirated or swallowed. This unusual situation may require a series of x-rays to be taken by a physician and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of any minor or dependent. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth. I give my permission to my dentist to make any/all changes and additions as necessary, with verbal consent.

I hereby authorize Dr. Cara Jones, DDS or dental auxiliaries to proceed with and perform the dental cleanings, restorations and treatments as explained to me at any future appointments. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees.

Signature of Patient or Guardian: _____ Date: _____

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Composite Fillings, Crowns and Bridges

- Sensitivity of Teeth: Sometimes after preparation of teeth for the placement of any restoration, the prepared teeth may exhibit sensitivity. The sensitivity may be mild to severe and may last only for a short period of time or much longer. If such sensitivity is persistent or lasts for extended periods of time, I agree to notify the dentist inasmuch as this may be a sign of more serious problems.
- Necessity for Root Canal Treatment: When fillings, crowns or bridges are placed or replaced, the preparation of the teeth for fillings often necessitates the removal of tooth structure adequate to ensure that the diseased or otherwise compromised tooth structure provides sound tooth structure for placement of the restoration. At times, this may lead to exposure or trauma to underlying pulp tissue. Should the pulp not heal, which often times is exhibited by extreme sensitivity or possible abscess, root canal treatment may be required.
- Aesthetic Appearance: Effort will be made to closely approximate the natural tooth color. However, due to the fact that there are many factors which affect the shades of teeth, it may not be possible to exactly match the tooth coloration. Also, over a period of time, composite fillings, because of mouth fluids, different foods eaten, smoking, etc. may cause the shade to change. The dentist has no control over these factors.
- Breakage, Dislodgement or Bond Failure: Many factors can contribute to breakage, dislodgement or bond failure such as chewing excessively hard materials, changes in biting forces, traumatic blows to the mouth, etc. Due to extreme masticatory pressures or other traumatic forces, it is possible for composite fillings or restorations bonded with composite resin cements to be dislodged or fractured. Unobservable cracks may develop in restorations but does not dislodge until chewing soft foods or possibly for no apparent reason. Breakage or chipping seldom occurs due to defective material or construction unless it occurs soon after placement. The resin-tooth bond may fail, resulting in leakage or recurrent decay. Fillings and/or crowns may need to be replaced if this occurs.
- Longevity of fillings, crowns or bridges: There are many variables that determine how long crowns and bridges can be expected to last. Among these are some of the factors mentioned in preceding paragraphs. Additionally, general health, good oral hygiene, regular dental checkups, diet, etc. can affect longevity. Because of this, no guarantees can be made or assumed to be made.

I understand that I will be given the opportunity to ask questions and receive answers to my satisfaction prior to starting treatment. I do voluntarily assume any and all possible risks which may be associated with any phase of this treatment in hopes of obtaining the desired and/or any results from the treatment to be rendered to me.

Signature of Patient or Guardian: _____ Date: _____