MOUNTAIN TOP
periodontics & implants

8000 E. Prentice Ave. Unit D7
Greenwood Village, CO 80111
(303) 740-0080

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Patient's Email: _____ Pref. Name: _____

Birth Date: _____ Marital Status: M S D W

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ SS #: _____

Employer/School: _____

Address: _____

Occupation: _____ Work Phone #: _____

Can you be reached at this number? Yes No Leave a message: _____

Has anyone in your family ever been treated in our office? Y N Name: _____

Spouse/Parent: _____ Work Phone #: _____

Employer: _____

Nearest relative not living with you: _____ Phone #: _____

Physician _____ Phone #: _____

General Dentist _____ Phone #: _____

Whom may we thank for referring you to our office? _____

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DENTAL INSURANCE INFORMATION

Primary Insurance Policy

Policy Holder Name: _____ Birth Date: _____ SS#: _____

Policy Holder's Employer: _____ Relation to patient: _____

Policy Holder's Work Phone #: _____ Insurance Co.: _____

Ins. Co. Address: _____

City/State: _____ Zip Code: _____

Ins. Co. Phone #: _____ Group/Policy #: _____

Secondary Insurance Policy

Policy Holder Name: _____

Birth Date: _____ SS#: _____

Policy Holder's Employer: _____ Relation to patient: _____

Policy Holder's Work Phone #: _____ Insurance Co.: _____

Ins. Co. Address: _____

City/State: _____ Zip Code: _____

Ins. Co. Phone #: _____ Group/Policy #: _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature/Guardian: _____ Date: _____

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PATIENT MEDICAL HISTORY

DENTAL HISTORY

Patient Name: _____ Dentist Address: _____

Reason for Visit:_____ Dentist City/State: _____

General Dentist: _____ Dentist Phone: (_____) _____

MEDICAL HISTORY

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

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 ⑤ No ⑤

AIDS/HIV	☐Yes	☐No	Glaucoma	☐Yes	☐No	Shortness of breath	☐Yes	☐No
Anemia	☐Yes	☐No	Headaches	☐Yes	☐No	Sinus trouble	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No	Heart murmur	☐Yes	☐No	Skin rash	☐Yes	☐No
Artificial heart valves	☐Yes	☐No	Heart problems	☐Yes	☐No	Special diet	☐Yes	☐No
Artificial joints	☐Yes	☐No	Hepatitis Type _____	☐Yes	☐No	Stroke	☐Yes	☐No
Asthma	☐Yes	☐No	Herpes	☐Yes	☐No	Swollen feet or ankles	☐Yes	☐No
Back problems	☐Yes	☐No	High blood pressure	☐Yes	☐No	Swollen neck glands	☐Yes	☐No
Bleeding abnormally, with extractions or surgery	☐Yes	☐No	Jaundice	☐Yes	☐No	Thyroid problems	☐Yes	☐No
Blood disease	☐Yes	☐No	Jaw pain	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Cancer	☐Yes	☐No	Kidney disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Liver disease	☐Yes	☐No	Tumor or growth on head or neck	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No	Low blood pressure	☐Yes	☐No	Ulcer	☐Yes	☐No
Circulatory problems	☐Yes	☐No	Mitral valve prolapse	☐Yes	☐No	Venereal disease	☐Yes	☐No
Congenital heart lesions	☐Yes	☐No	Nervous problems	☐Yes	☐No	Weight loss, unexplained	☐Yes	☐No
Cortisone treatments	☐Yes	☐No	Pacemaker	☐Yes	☐No	Major surgery? _____	☐Yes	☐No
Cough, persistent or bloody	☐Yes	☐No	Psychiatric care	☐Yes	☐No	Hospitalized for? _____	☐Yes	☐No
Diabetes	☐Yes	☐No	Radiation treatment	☐Yes	☐No	Do you wear contact lenses?	☐Yes	☐No
Emphysema	☐Yes	☐No	Respiratory disease	☐Yes	☐No	Take any non-prescribed drugs?	☐Yes	☐No
Epilepsy	☐Yes	☐No	Scarlet fever	☐Yes	☐No	If yes, what and how often? _____		
FOR WOMEN ONLY: Pregnant? Due date_____	☐Yes	☐No	Taking birth control pills?	☐Yes	☐No	Are you nursing?	☐Yes	☐ No

List any medications you are currently taking and the correlating diagnosis:
Med:_____ Dose:_____ Frequency:_____
For:_____
Med:_____ Dose:_____ Frequency:_____
For:_____
Med:_____ Dose:_____ Frequency:_____
For:_____ Med:_____ Dose:_____
Frequency:_____ For:_____
Pharmacy name: _____Phone (_____) _____

Indicate any allergies to the following:

☐Aspirin	☐Iodine	☐Penicillin
☐Barbiturates	☐Latex	☐Sulfa
☐Codeine	☐Local anesthetic	☐Other _____

I attest that the dental and medical information above is true and accurate. I accept full responsibility for any information not shared with the doctor.

Patient (or Guardian) Signature:_____ **Date:** _____