



PATIENT INFORMATION

Name _____ Patient's Email _____

Pref. Name _____ Birth Date _____ Marital Status M S D W (check one)

Address _____ City/State _____ Zip code _____

Home # (_____) _____ Cell # (_____) _____ Social Security # _____

Occupation _____ Work Phone # (_____) _____

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

Employer / School _____ Address _____

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

Emergency Contact _____ Phone # (_____) _____

General Dentist _____ Phone # (_____) _____

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

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 _____



Patient Name: _____

MEDICAL HISTORY

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

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor/growth on	
Bleeding abnormally, with extractions/surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Major surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigar/tobacco smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes _____	
Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Take Aspirin daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Take any blood thinners?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent/bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes _____	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Take any meds for Osteoporosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes _____	

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: Indicate any allergies to the following:

Med: _____ Dose: _____ Frequency: _____ For: _____

Med: _____ Dose: _____ Frequency: _____ For: _____

Med: _____ Dose: _____ Frequency: _____ For: _____

Med: _____ Dose: _____ Frequency: _____ For: _____

Pharmacy name: _____ Phone (____) _____

Allergies:

- Aspirin Iodine Latex Codeine Local anesthetic Penicillin Sulfa
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: ____/____/____



GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, may have some inherent risks.

These risks are seldom great enough to offset the benefits of treatment but should be considered when making treatment decisions.

Benefits of dental treatment can include relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines, which most often lead to clinical success, there are occasional cases, as in any medical treatment, that do not turn out as planned. We will do our best to assure that it does. Please feel free to ask questions regarding all dental procedures that are recommended to you.

THANK YOU FOR READING THE GENERAL CONSENT AND OUR FINANCIAL POLICY. LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

Signature of Patient: _____ Date: _____

Signature of Parent (if minor patient): _____ Date: _____



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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

WE ACCEPT CASH, CHECK, AND VISA/MASTERCARD/AMEX. FINANCIAL PAYMENT PLANS ARE AVAILABLE THROUGH CARECREDIT (6 & 12-month interest free options)

_____ Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

_____ Missed Appointments

Unless cancelled at least 2 business days in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you and our other patients better by keeping scheduled appointments.

_____ Unaccompanied Minors

Proposed treatment sometimes changes during the procedure due to the needs of the tooth. To assure quality care of the patient, it may be necessary to proceed without the consent of the parent or the guardian. The parent or guardian is responsible for payment the day of treatment and will be financially responsible for the necessary changes in the minor's treatment.

_____ Late Accounts

Balances due for 60 days will be considered delinquent. We reserve the right to forward accounts, which are delinquent to an independent service for collection. In the event your account should become delinquent, by signing below, you are acknowledging that you will be responsible for the balance, interest, court costs and/or attorney fees.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature of Patient or Responsible Party: _____ Date _____



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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Phone: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations. Your protected health information may be discussed with your general dentist and or your insurance company.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting:

Contact Person: Mountain Top Periodontics & Implants. - c/o HIPAA Compliance Officer Address: 8000 Prentice Dr. Suite D7, Greenwood Village, CO 80111 Phone: 303-740-0080



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Right to Revoke

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

REVOCAION OF CONSENT (Do Not Sign This Portion Unless You Are Revoking Your Consent)

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____