

MEDICAL HISTORY

Name: _____ Date of Birth: _____

- 1. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what reason? _____
- 2. Are you having dental problems at this time? Yes No
- 3. Do your gums bleed at any time? Yes No
- 4. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? Yes No
If yes, please list. _____
- 5. Have you ever had excessive bleeding requiring special treatment? Yes No
- 6. Check any of the following which you have had or have at present:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV Positive (AIDS) |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hepatitis A (Infectious) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Heart Murmur/Mitral Valve |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Psychiatric Treatment |

- 7. Do you have any disease, condition or problem not listed? If so, please list Yes No
- _____
- _____

- 8. List all medications you are taking at this time. _____
- 9. Are you a smoker?..... Yes No
- 10. Do you use or have you ever used recreational drugs?..... Yes No
- 11. Do you ever wake up from sleep short of breath? Do you snore?..... Yes No
- 12. Do you clench or grind your teeth? Yes No
- 13. Has your medication doctor ever said you have cancer or a tumor?..... Yes No
- 14. Women: Are you pregnant Yes No If yes, what month are you due? _____

Updates (date & initial) _____

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can make you as comfortable as possible.

1. Please rate, in order of value, what is most important to you in dental care: (The most important will be #1)

- Preventative Care
- Only what is necessary at the time: cost is important
- Comprehensive, quality care, best looking results
- Other _____

2. Please rate, as in #1, what is most important to you in your relationship with a dentist.

- Show me what he/she is doing or planning to do so I can clearly see what is happening
- Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment
- Make sure I feel comfortable and informed at all times.

3. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)

1 2 3 4 5 6 7 8 9 10

4. Are you concerned about: (please circle yes or no)

- | | | |
|--------------------------|-----|----|
| Replacing missing teeth | Yes | No |
| Eliminating any cavities | Yes | No |
| Gum disease | Yes | No |
| Bad breath | Yes | No |
| Snoring at night | Yes | No |
| Color of your teeth | Yes | No |
| Appearance of your smile | Yes | No |

5. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)

1 2 3 4 5 6 7 8 9 10

6. When we review your treatment plan with you, would you like to know (please check one):

- The big picture of what needs to be done
- All the treatment details along the way



DENTAL INSURANCE POLICY

Colorado Family Orthodontics proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

-----PATIENT ACKNOWLEDGMENT AND AUTHORIZATION-----

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Colorado Family Orthodontics. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

APPOINTMENT DEPOSIT REQUIREMENT

Colorado Family Orthodontics requires a minimum \$50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of \$300.00 or more. The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Colorado Family Orthodontics requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature: _____ Date: _____

CANCELLATION POLICY

Colorado Family Orthodontics makes an effort to see patients on time in order to give patients the care they deserve. Therefore, we ask that you **please give 24 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge a \$50.00 cancellation fee for lack of proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, _____, have had the opportunity to review Colorado Family Orthodontics's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____