ABOUT YOU

Date ____

Name: ____
First MI Last

Preferred Name: ___________________________________

Social Security Number: ____________________________

Home Address: _____________________________________

____
City State Zip

Birthdate: _____________ Age: _____ Sex: M F

Single Married Widowed Divorced Minor

Contact Information

Home Phone: ________________ Cell: ________________

Work: ____________________ Alternate: ______________

Email: ____

Your Employer __________________________________

Occupation ____________________ How Long? ________

In Case of Emergency, Contact

Specify someone who does not live in your household

Name ____

Relationship ___________________________________

Phone (_______) ___________________________________

How did you hear about us?

__ Convenient location

__ Family member is seen at the practice

__ Referred by a friend

Who may we thank for referring you to our office?

____

__ Received a welcome letter in the mail

__ Google __ Yelp __ Bing __ Facebook

__ Newspaper __ TV __ Radio __ Bus bench

__ VA __ Direct Mail (Quality connections)

__ Other: ____

BENEFITS

Do you have dental benefits? Yes No

Do you have medical benefits? Yes No

Primary Insurance

Name of Subscriber: ______________________________

Date of Birth: ____________________________________

Social Security or ID#: ____________________________

Group #: ____

Insurance Co. Name: ______________________________

Insurance Co. Address:

____

____
City State Zip

Secondary Insurance

Name of Subscriber: ______________________________

Date of Birth: ____________________________________

Social Security or ID#: ____________________________

Group #:____

Insurance Co. Name: ______________________________

Insurance Co. Address: ____________________________

____
City State Zip

Medical Insurance

Name of Subscriber: ______________________________

Employer's Name: _________________________________

Employer's Phone#: _______________________________

Employer's Address: ______________________________

____
City State Zip

STATEMENT OF CONFIRMATION

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my insurance information, address or phone number.

SIGNATURE: _________________________________

MEDICAL HISTORY

Have you ever had any of the following diseases or Medical problems?

Y N Anemia	Y N Heart Disease
Y N Angina	Y N Heart Murmur
Y N Anti Clot Med.	Y N Hemophilia
Y N Anxiety Attacks	Y N Hepatitis
Y N Arthritis	Y N Herpes
Y N Artificial Joints	Y N High Blood Pressure
Y N Asthma	Y N HIV/AIDS
Y N Back Injury	Y N Jaundice
Y N Blood Disease	Y N Kidney Disease
Y N Bypass Surgery	Y N Liver Disease
Y N Cancer Therapy	Y N Low Blood Pressure
Y N Chemical Dependency	Y N Nervous Disorder
Y N Chest Pain	Y N Pacemaker
Y N Chronic Cough	Y N Prolapsed Valve
Y N Coronary Occlusion	Y N Psychiatric Disorder
Y N Coughing Sputum	Y N Radiation Treatment
Y N Diabetes	Y N Respiratory Problems
Y N Dizziness	Y N Sinus Problems
Y N Eating Disorder	Y N Stomach Problems
Y N Epilepsy/Fainting	Y N Stroke
Y N Excessive Bleeding	Y N Swollen Glands
Y N Fainting	Y N Thyroid Disease
Y N Frequent Headaches	Y N Tuberculosis
Y N Glaucoma	Y N Ulcers
Y N Hay Fever	Y N Weight Loss
Y N Head Injuries	Y N Heart Attack

Other: ______________________________

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Latex
Y N Seasonal	Y N Metals	Y N Penicillin
Y N Sulfa	Y N Other: ____________	

____

Physicians Name: ______________________

Phone: ____________ Last Visit: __________

Are you currently under care of a physician? Y N

If yes, please explain: ____________________ Do you smoke or chew tobacco? Yes No

Do you drink alcohol? Yes No How often? _____

MEDICAL HISTORY CONTINUED

Are you currently taking any drugs prescribed by a physician or dentist? Y N

If yes, please list: ______________________

For women: Are you pregnant? Yes No

If yes, how many months: ____________________

Have you had any surgeries? Yes No

If yes, please list: ______________________

Have you had any serious medical problems in the past?

Yes No If yes, please list: ____________________

DENTAL INFORMATION

When was your last dental visit? ________________

Were X-Rays taken? Yes No

Frequency of dental visits? ____________________

Do you have any dental concerns today? Yes No

If yes, please explain: ______________________

Do you need to be pre-medicated before dental treatment?

Y N If yes, please explain: ____________________

Have you ever had adverse effects to dental anesthetic?

Y N If yes, please explain: ____________________

Have you ever experienced difficulty becoming numb?

Y N If yes, please explain: ____________________

How do you feel about the appearance of your teeth?

____

Would you change anything about your smile?

____

Are there any old fillings or dental work you do not like?

Y N If yes, please explain: ____________________

Would you like your teeth to be whiter? Yes No

Please check if the description applies to you:

__ Difficulty chewing on the right	__ Popping/Clicking
__ Difficulty chewing on the left	__ Grinding/Clenching
__ Bleeding gums	__ Headaches/Neck aches
__ Frequent cavities	__ Ear aches/ Ringing

Signature of Treating Doctor: ____________________

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE

I, ________________________________, have had the opportunity to review Prestige Dental Centers Notice of Privacy Practices (The entire legal notice is displayed at the front patient check-in desk)

Signature: ____ Date: ___________________________________

CANCELLATION POLICY

Our policy requires that you give our office **48 hours** notice in the event in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. We reserve the right to charge a fee of $50.00 to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointment can be scheduled nor can records be transferred without the payment of this fee. We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: ____ Date: _____________________________________

DENTAL INSURANCE

Prestige Dental Centers accepts most dental insurance plans. We will file all claims for our patients as a courtesy. In the event of a treatment plan, we create a reasonable estimate of insurance procedures covered and patient co-payments. This estimate is based on the insurance policy contracted rates, the general breakdown of benefits we receive through the verification process and our experience of common exclusions. The treatment plan **estimate is not a guarantee of insurance payment. Your benefits are determined at the discretion of the insurance company and not determined until after a claim has been issued.** We provide treatment estimates as a courtesy to minimize the out-of-pocket cost to our patients. **Any and all patient co-payments are due prior or at the time of service.**

The patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding the balance due with an explanation. Payment is due upon receipt. We accept Cash, Money Orders, Visa, Mastercard, Discover, Care Credit and in state personal checks. Past due accounts will be subject a monthly interest fee of 1.5%, plus recovery fees incurred in the process.

SIGNATURE:____ Date: ______________________________________

CONSENT FOR TREATMENT

1. I herby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis including consultation with adjunct healthcare providers as he deems necessary.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance, including other healthcare providers, as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

____ ________________________
Patient Signature Date

____ ________________________
Parent or Responsible Party Date

ACKNOWLEDGEMENT OF RECIEPT OF SURPRISE/BALANCE BILLING DISCLOSURE FORM

I, ____________________________, have had the opportunity to review Colorado Surprise/Balance Billing Disclosure Form (The entire notice is displayed at the front patient check-in desk) House Bill 19-1174 went in effect Jan 01, 2020.

Signature: ____ Date: ____________________________

MEDICAID PATIENTS

I understand I must submit my current Medicaid identification card along with a picture ID on the day service is rendered.

I am aware that I am financially responsible for services not covered by the Colorado Medicaid Dental Program. Colorado Medicaid Dental Program has a maximum of $1,000 for adults 21 years and older. I am aware that I am financially responsible for any services that exceed the $1,000 maximum.

I also understand after Medicaid has processed the claim there may be a portion of the balance which will be my responsibility. I agree to pay this balance within 30 days.

____ ________________________
Member Signature Date

____ ________________________
Parent or Guardian Signature (if the member is under the age of 18) Date