PATIENT MEDICAL HISTORY Please print legibly

Salutation	First Name	Last Name	M.I.
Home Phone ( )	Cell Phone ( )	Date of Birth	
Work Phone ( )	Fax ( )	Gender	
Home Address	City/State/Zip		
Employer Name	Occupation		
Employer Address	Social Security Number		
Referring Doctor	Family Dentist		
Family Physician	Family Physician Phone ( )		
Guarantor	Date of Last Physical Exam / /		
Home E-mail	Work E-mail		
Insurance Company	Address		
Subscriber's Name	Subscriber's Social Security Number		
Subscriber's DOB	Group #	Relationship	

Height: _____FT_____IN Weight: _____Lbs.

	Yes	No	Don't Know
Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain.			
Has there been any change in your general health within the past year? If yes, please explain.			
Are you under the care of a physician for a current problem? If yes, explain.			
Have you been hospitalized within the past 5 years? Please specify.			
Have you received therapy for alcoholism or drug addiction during the past 5 years?			
Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/ medications?			
Is there any condition concerning your health that the doctor should be told?			
Do you wish to speak to the doctor privately about anything?			
Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
Have you ever required a blood transfusion?			
Have you ever had surgery and/or radiation for a tumor, growth, or other condition?			
Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor.			
Are you required to take antibiotics prior to dental treatment?			

Please continue

Do you have or have you had any of the following?

- ☐ High blood pressure
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Prosthetic heart valve
- ☐ Asthma
- ☐ Chest pain, angina
- ☐ Heart surgery
- ☐ Emphysema
- ☐ History of alcohol abuse
- ☐ Sinus Trouble
- ☐ Stomach Ulcers, Colitis
- ☐ Swollen Ankles, arthritis or joint disease
- ☐ Delay in healing
- ☐ X-ray treatment or chemotherapy
- ☐ Eye disease or Glaucoma
- ☐ Thyroid problems
- ☐ Psychiatric treatment
- ☐ Cancer
- ☐ Dialysis
- ☐ Bronchitis, chronic cough
- ☐ Difficult breathing or other lung trouble
- ☐ Wear contact lenses
- ☐ Heart murmur or prolapsed valve
- ☐ Congenital heart disease
- ☐ Blood disorder
- ☐ Allergy to latex
- ☐ Venereal disease
- ☐ Low blood pressure
- ☐ Cardiac pacemaker
- ☐ Tuberculosis
- ☐ On a diet

☐	Hepatitis, Jaundice, Liver disease	☐	Infectious mononucleosis
☐	Fainting spells, Seizures	☐	Diabetes
☐	Temporomandibular Joint Problem	☐	Kidney problems
☐	Irregular heart beat	☐	Epilepsy
☐	Hay fever or sinus problems	☐	Low blood sugar
☐	Chronic Fatigue or night sweats	☐	Contagious Diseases
☐	Bruise easily	☐	Problems with immune system
☐	Joint prosthesis (hip, knee, etc.)	☐	History of drug abuse
☐	Cardiovascular disease: heart attack, stroke or bypass	☐	Gallbladder trouble

	Yes	No	Don't Know
Are you taking any herbal medicine (i.e., St. John's Wort)?			
Have you ever taken the "fen-phen" diet?			
Do you have any disease, condition or problem not listed above? Specify.			

Are you taking bisphosphonates now or have you ever taken them in the past (Fosamax)? YES or NO
If Yes, How long were you on the medication? _____
If you are currently off the medication, how long ago did you discontinue? _____

Please continue:
Women only:

Possibility of pregnancy:	YES / NO	Nursing:	YES / NO
Estimated delivery date:		Taking birth control pills:	YES / NO

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

Injury:

This visit is related to an accident	YES / NO	Work related:	YES / NO
Date of injury:			
Insurance company handling the claim:			
Claim Number:			

EMERGENCY CONTACT INFO:

First name: _____Last name: _____
Relation to patient: _____
Home number: _____
Work number: _____

Would you like to authorize release of your health records (to include medical history, treatment notes, x-rays, account information and entire record) to anyone other than yourself? If so please indicate name, phone number and relationship below.

YES or NO If yes, please name individuals:_____

Are you taking any medication or drugs? If yes, please list them below.

Start Date	Dosage	Frequency	Medication Prescribed

Patient or Guardian Signature _____ Date_____

Prescription Drug Monitoring Notification

By signing this form, you confirm that you have been notified that if you receive a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado, certain identifying prescription information, including the name of patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses of controlled substances – like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances (narcotic drugs like painkillers, muscle relaxers and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants or any other category of prescription medication.

Only authorized individuals, like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstances, can access the database and only for tightly defined uses. As long as you are using controlled drugs appropriately, there shouldn't be reason for concern. If you do not want your information in the database, please ask your dentist to pre-scribe non-narcotic drug for you.

More information about Colorado's prescription drug monitoring program, including copies of individual prescription drug records stored in the database, can be obtained from Colorado State Department of Regulatory Agencies by calling 303-894-5957 or by visiting http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm .

I have read and understand this notification.

Name _____Date_____

Financial Policy

As a courtesy, if you have dental insurance we will bill your carrier, provide documentation, claim forms, radiographs, and treatment narratives. We request that you pay your co-payment at the time of service. We accept cash, checks, Care Credit, Visa, MasterCard, American Express, and Discover.

Those with dental insurance: We will estimate the portion your insurance is going to pay. Since this varies for each individual, usually 20 - 75% of the cost of the procedure is required at the time of service. We will bill your insurance for you. ***Insurance companies routinely indicate that coverage verification does not guarantee payment. This means while we have done our best to estimate your out of pocket expense, when the insurance company actually processes the claim, the insurance payment may be less than expected. In some cases the dental insurance may even pay more than estimated.***

If your insurance pays more than the estimated amount, a refund check from this office will be mailed within 1 month from the date payment is received in this office.

If your insurance pays less than the estimated amount, you will receive a statement from this office. NOTE: ***If your insurance company does not reimburse us after 2 submissions, you will be responsible for the remainder of the balance since we were unable to collect from them.***

Broken appointments: Many people see us because they are in severe pain and want to be seen immediately but a specific amount of time is reserved especially for your dental needs. We require at least 48 hours notice to avoid a $100.00 cancellation fee.

Print Name:_____

Sign Name:_____ Date_____