GREENWOOD
DENTAL ARTS

PATIENT INFORMATION

(PLEASE PROVIDE US WITH A COPY OF YOUR PICTURE ID) DATE_____

FIRST NAME _____ LAST NAME _____

PREFERRED NAME _____ BIRTH DATE _____ GENDER _____

ADDRESS _____

CITY/STATE/ZIP _____

CELL PHONE _____ HOME PHONE _____ WORK _____

MARITAL STATUS _____ EMAIL _____

PREFERRED METHOD OF COMMUNICATION? ☐ Phone call ☐ Text ☐ Email

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

MEDICAL HISTORY

Although we primarily treat the area in and around your mouth, your mouth is the entrance to the entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

Please list your Primary Care Physician? _____ Phone: _____

Are you currently being treated for any medical condition? If yes, please explain _____

Have you ever been hospitalized or had a major operation? If yes, please explain _____

Have you ever had a serious head or neck injury? If yes, please explain _____

Please check any conditions below applicable to you.

☐ Acid Reflux/GERD	☐ Drug Addiction	☐ Leukemia
☐ AIDS/HIV Positive	☐ Easily Winded/Shortness of Breath	☐ Liver Disease
☐ Alzheimer's Disease	☐ Emphysema	☐ Low Blood Pressure
☐ Anaphylaxis	☐ Epilepsy or Seizures	☐ Lung Disease
☐ Anemia	☐ Excessive Bleeding	☐ Numbness/Tingling/Back pain
☐ Angina	☐ Excessive Thirst	☐ Osteoporosis
☐ Anxiety	☐ Fainting Spells/Dizziness	☐ Pain in Jaw Joints
☐ Arthritis/Gout	☐ Family history of Diabetes	☐ Parathyroid Disease
☐ Artificial Heart Valve	☐ Family history of Heart Disease	☐ Psychiatric Care
☐ Artificial Joint Date:_____	☐ Frequent Cough	☐ Radiation Treatments
☐ Asthma	☐ Frequent Diarrhea	☐ Recent Weight Loss
☐ Blood Disease	☐ Frequent Headaches	☐ Rheumatic Fever
☐ Blood Transfusion	☐ Glaucoma	☐ Rheumatism
☐ Breathing Problems	☐ Hay Fever/Chronic Allergies	☐ Scarlet Fever
☐ Bruise Easily	☐ Heart Attack/Failure or Arrythmia	☐ Shingles
☐ Bypass Surgery/Stint Placement	☐ Heart Pacemaker	☐ Sickle Cell Disease
☐ Cancer	☐ Heart Trouble/Disease	☐ Sinus Trouble
☐ Celiac Disease	☐ Hemophilia	☐ Sjogren's Syndrome
☐ Chemotherapy	☐ Hepatitis A	☐ Stomach/Intestinal Disease
☐ Chest Pains	☐ Hepatitis B or C	☐ Stroke
☐ Cold Sores/Fever Blisters	☐ Herpes	☐ Swelling of Limbs
☐ Congenital Heart Disorder	☐ High Blood Pressure	☐ Thyroid Disease
☐ COPD	☐ High Cholesterol	☐ Tonsilitis
☐ Cortisone Medicine	☐ Hives or Rash	☐ Tuberculosis
☐ Dementia	☐ Hypoglycemia	☐ Tumors or Growths
☐ Depression	☐ Immune system dysfunctions	☐ Ulcers
☐ Diabetes [ ] Type I [ ] Type II	☐ Irregular Heartbeat	☐ Venereal Disease
☐ Difficulty Hearing	☐ Kidney Problems	☐ Other _____

Please list any medications or supplements you are currently taking (attach list if necessary).

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate medications? ☐ YES ☐ NO
Do you regularly monitor your blood pressure? ☐ YES ☐ NO
Do you regularly monitor your blood sugar? ☐ YES ☐ NO
Do you take medication for blood pressure or cholesterol? ☐ YES ☐ NO
Have you ever been diagnosed with prediabetes? ☐ YES ☐ NO
Do you feel that you are more than 10% above your ideal body weight? ☐ YES ☐ NO
Have you received the HPV vaccine? ☐ YES ☐ NO
Do you use tobacco? ☐ YES ☐ NO
If yes: Type of tobacco? _____
Frequency? _____
Number of years used? _____
Have you recently quit smoking or chewing tobacco or any other products? ☐ YES ☐ NO
Do you use controlled substances? ☐ YES ☐ NO

Are you allergic to any of the following?
☐ Penicillin ☐ Local Anesthetics
☐ Aspirin ☐ Sulfa drugs
☐ Latex ☐ Codeine
☐ Metal ☐ Acrylic

Other, please explain:

Women:
Are you pregnant or trying to get pregnant? ☐ YES ☐ NO
Nursing? ☐ YES ☐ NO
Taking oral contraceptives? ☐ YES ☐ NO

In case of Emergency, please contact Name: _____ ***Phone:*** _____ ***Relationship:*** _____

DENTAL HISTORY

Are you currently in discomfort requiring our immediate attention? ☐ YES ☐ NO
Have you had regular dental checkups? ☐ YES ☐ NO
Do you consider yourself prone to cavities? ☐ YES ☐ NO
Do you frequently consume sugary/acidic foods/beverages? ☐ YES ☐ NO
Do you wear removeable dentures or partials? ☐ YES ☐ NO
Are you happy with these? ☐ YES ☐ NO
If no, please explain: _____
Have you ever had any gum treatments? ☐ YES ☐ NO
Do your gums bleed, feel tender, or irritated? ☐ YES ☐ NO
If yes, please explain: _____
Do you regularly use dental floss? ☐ YES ☐ NO
Do you suffer from dry mouth? ☐ YES ☐ NO
Are you concerned with chronic bad breath? ☐ YES ☐ NO
Have you lost any teeth besides wisdom teeth? ☐ YES ☐ NO
Do you clench or grind your teeth? ☐ YES ☐ NO
Do you have chronic headaches, neck or shoulder pain? ☐ YES ☐ NO
Does your jaw feel tired/sore when you wake up? ☐ YES ☐ NO
Do you or have you used a night guard? ☐ YES ☐ NO
Have you ever had orthodontic treatment? ☐ YES ☐ NO
If yes, when? _____
Any pain, unhealed injuries or growths around your mouth? ☐ YES ☐ NO
Have you ever completed OralDNA testing? ☐ YES ☐ NO

Are you apprehensive about dental treatment? ☐ YES ☐ NO
Have you ever had adverse reactions to local anesthetic? ☐ YES ☐ NO
Do you have any objections to its use?
Have you ever had complications during dental treatments? ☐ YES ☐ NO

I think my present state of oral health is:
☐ Excellent
☐ Average
☐ Poor

My mouth is:
☐ Very comfortable
☐ Moderately comfortable
☐ Uncomfortable

I would like my treatment to:
☐ Be the best possible in health and appearance
☐ Be very conservative
☐ Be only what is needed to stay out of pain

Are you pleased with the appearance of your mouth? ☐ YES ☐ NO
If no, please explain: _____
Is it important to you to keep your teeth? ☐ YES ☐ NO
If no, please explain: _____

If you could change one thing about the health or appearance of your mouth, what would it be? _____

CONSENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be detrimental to my health. It is my responsibility to inform the dental office of any changes in medical status. I consent to treatment as necessary or desirable in the care of the patient first named above, for the diagnosis of dental disease, deformity or treatment of dental emergency. These procedures may include but are not limited to radiographs, models, photos, and intraoral exam. In the case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the treatment will be explained in advance. I give my consent to the use of local anesthetics and relaxants for completing the necessary dental treatment. I also acknowledge full responsibility for the payment of such services and agree to pay them in full, at the time of service unless other arrangements are made in advance.

Signature of Patient, Parent or Guardian _____ **Date** _____

For Office Use Only
Reviewed by: Date

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ADULT AIRWAY QUESTIONNAIRE

Your Name: _____ Date of Birth: _____

AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____

Do you breathe through your mouth? During the day? Y N At night? Y N

Do you frequently get a dry throat or non-productive cough? Y N

Do you have any nasal allergies? Y N

Do you snore or have you been told you snore while sleeping? Y N

Do you stop breathing or pause breathing while sleeping? Y N

Do you wake up fatigued? Y N

Do you have trouble falling asleep? Y N

Do you have trouble staying asleep? Y N

Do you have morning tension or migraine headaches? Y N

Do you easily get tired and fall asleep during the day? Y N

Do you clench or grind your teeth during the night? Y N

Do you clench or grind your teeth during the day? Y N

Do you have any facial pain? Y N

Do you take sleep aids before going to bed? Y N

Do you usually drink alcohol before going to bed? Y N

Do you suffer from hypertension (high blood pressure)? Y N

Have you been diagnosed with:

- Chronic Fatigue Syndrome? Y N
- Irritable Bowel Syndrome? Y N
- Fibromyalgia? Y N
- Temporomandibular Syndrome (TMJD)? Y N

Do you use a cPAP? Y N Currently? Y N In the past? Y N

Do you use oxygen at night? Y N

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices and allow the office to share information about my treatment with the following individuals (please give specific names and phone numbers, i.e. family members, other dentists, physicians, insurance companies, attorneys, etc.):

_____ _____
_____ _____
_____ _____

Print Patient Name: _____ **Relationship to patient:** _____

Signature of Patient, Parent or Guardian _____ **Date** _____

For Office Use Only:
We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify): _____

HIPAA AUTHORIZATION FOR EDUCATIONAL PURPOSES

I, _____, authorize Greenwood Dental Arts to use photos, x-rays, and/or other dental information for educational purposes.

By initialing below, I authorize the use and/or disclosure of the following information:

_____ Still photos or video footage for use in educational lectures, educational discussions, and/or, publications. I understand that Dr. Alconcel, Dr. Fischer, or Dr. Johnson will let me know prior to using my images.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorize the disclosure of the protected health information as stated.

Print Patient Name: _____ **Relationship to patient:** _____

Signature of Patient, Parent or Guardian _____ **Date** _____

Declined_____

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FINANCIAL AGREEMENT

All patient balances are due immediately after treatment is rendered. Should a balance accrue on the account, a statement will be sent, and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days, interest may be applied to the entire account balance and a revised statement, with the new balance due immediately, will be sent. If applicable, a returned check fee will also be applied and must be payable for each check payment returned to the practice. Financial arrangements are made on an individual basis.

Full payment is due at the time of service and a non-refundable deposit will be required to schedule extensive treatment appointments with Dr. Alconcel, Dr. Fischer, or Dr. Johnson.

We accept Cash, Check, Visa, MasterCard, Discover, and American Express

I have read, understand, and agree to the above financial agreement for payment of services provided. I understand that I am ultimately responsible for payment of all charges for services rendered to me and/or my family.

_____	_____	_____
Print Patient Name	**Signature of Patient or Responsible Party**	**Date**

INSURANCE

We are happy to work with you to help you maximize your insurance benefit at your request. As a courtesy to you, if you have provided us with sufficient information of your dental insurance policy, we will file all necessary documents with your insurance company for direct reimbursement to you. It is important you provide us with the most up to date information or we will not be able to assist you in insurance claim submission.

Dental insurance is a contract between you and your insurance provider. As the patient, it is your responsibility to familiarize yourself with your specific dental insurance policy. We are an independent provider and we do not guarantee any benefits you will receive from your insurance company. Ultimately, the cost of treatment is your responsibility.

PRIMARY INSURANCE INFORMATION

NAME OF INSURED _____RELATIONSHIP TO INSURED _____

INSURED SSN _____ INSURED DATE OF BIRTH _____

INSURANCE COMPANY _____ EMPLOYER GROUP_____

INSURANCE ADDRESS_____ CITY/STATE/ZIP _____

INSURANCE PHONE _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED _____RELATIONSHIP TO INSURED _____

INSURED SSN _____ INSURED DATE OF BIRTH _____

INSURANCE COMPANY _____ EMPLOYER GROUP_____

INSURANCE ADDRESS_____ CITY/STATE/ZIP _____

INSURANCE PHONE _____

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APPOINTMENT AGREEMENT

Our goal is to provide high quality care to our patients and honor their time commitments as well. When you schedule an appointment with us, we reserve that time and prepare in anticipation of serving you so we ask you to partner with us in arriving on time for your scheduled appointment.

Should you need to reschedule, we kindly request that you contact us, during normal business hours, with **a minimum of 48 hours notice.** We understand that conflicts arise, however, failing your appointment or canceling without adequate notice more than once will result in a **$95 charge**.

Additionally, we do not accept appointment changes or cancellations via text or voicemail.

Any patient who is late for their appointment may be considered a "no show" and may need to be rescheduled. Patients who continue to no-show and/or cancel without notice will be required to place a non-refundable deposit to reserve future appointment times.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The Doctor and/or Hygienist will try to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

I have read, understand, and agree to the above appointment policies.

_____	_____	_____
Print Patient Name	Signature of Patient or Responsible Party	Date

Dr. Lissa Alconcel, Dr. Charles Fischer, and Dr. Katie Johnson
8490 E Crescent Parkway, Suite 370
Greenwood Village, CO 80111

303.740.9353
info@greenwooddentalarts.com

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____

Practice/Provider Name: _____
Phone: _____
Address: _____

Please send records to: _____ Greenwood Dental Arts
(Please email to office@greenwooddentalarts.com)

_____ Other: _____

Information Requested:

__X__ Copy of Complete Dental Chart

__X__ Copy of Dental X-rays

_____ Other (e.g. models – describe) _____

Purpose(s) for which information is to be used:

_____ Transfer of records _____ Other: _____

Authorization: *I certify that this request has been made voluntarily and that the information given above is accurate and to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.*

_____ _____
Patient Signature Date