PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Additional Comments: Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Time 12:05 PM | Lone Tree Family Dentistry | Date 6/12/2019

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your 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. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed	○ Yes ○ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

LONE TREE Family Dentistry

Dental Health History

Date _____

Patient Name First_____ **MI** _____ **Last** _____ **Nickname** _____

Do you have any concerns that bring you into the office? _____

_____

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) _____

Have you ever been pre-medicated for dental treatment? Y ☐ **N** ☐

If yes why? _____

What has been your experience with the dentist in the past? _____

_____

Have you been anxious about having dental treatment? Y ☐ **N** ☐

If yes, would you be comfortable sharing why? _____

Do you clench or grind your teeth together in the daytime or nighttime or make them sore? Y ☐ **N** ☐

Do you have problems with sleep (i.e.,restlessness or teeth grinding) wake up with a headache or an awareness of your teeth? Y ☐ **N** ☐

Are you experiencing any pain right now? Y ☐ **N** ☐

If so please describe:_____

Are any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth? Y ☐ **N** ☐

Have you ever had periodontal (gum tissue) treatment such as deep cleanings, root planing or periodontal surgery? Y ☐ **N** ☐

If yes, when _____

Have you ever been told you have gum disease or that you have lost bone around your teeth? Y ☐ **N** ☐

Have you ever had orthodontic treatment? Y ☐ **N** ☐

Is there anything about the appearance of your teeth that you would like to change? (shape, color, size) Y ☐ **N** ☐

If so what _____

What concerns do you currently have with your oral health or smile? (check all that apply)

- ☐ JAW JOINT PAIN
- ☐ CLENCHING OR GRINDING OF TEETH
- ☐ DISCOLORED TEETH
- ☐ CROWDING/CROOKED TEETH
- ☐ SPACES IN BETWEEN TEETH
- ☐ LOOSE TOOTH/TEETH
- ☐ TOOTH SHAPE OR SIZE
- ☐ OVERBITE
- ☐ UNDERBITE
- ☐ UNCOMFORTABLE BITE
- ☐ OLD FILLINGS (GOLD OR SILVER)
- ☐ OLD CROWNS
- ☐ SPEECH PROBLEMS
- ☐ TOO MUCH GUM TISSUE WHEN I SMILE
- ☐ TOOTH SENSITIVITY TO HOT/COLD OR ANYTHING ELSE
- ☐ FOOD GETS CAUGHT IN BETWEEN TEETH

  IF YES WHERE?_____
- ☐ DIFFICULTY CHEWING

  IF YES WHERE?_____
- ☐ BAD BREATH
- ☐ OTHER _____

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

I authorize the following phone number to be used to leave protected health information.

Phone number: _____

I authorize Lone Tree Family Dentistry to release health information identifying me, including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services under the following terms and conditions:

1. Detailed description of the information to be released: Information pertaining to my oral health.

2. To whom may the information be released: Other Doctors or specialists, pharmacies, and insurance companies

3. The purpose(s) for the release: Referred Treatment, transfer of records, insurance claims, prescriptions.

4. While an active patient of Lone Tree Family Dentistry this authorization will not expire unless requested.

The following person(s) can receive my protected health information:

Name(s): _____ Relationship: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you refuse to sign you will however have to submit your own insurance claims, and we cannot do that on your behalf.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I ACKNOWLEDGE THAT I HAVE BEEN ABLE TO READ THE NOTICE OF PRIVACY PRACTICE. I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____Print Name: _____

LONE TREE
Family Dentistry

Consent

I give my authorization and consent for treatment after having an explanation of proposed treatment, alternatives, and risks by my doctor or dental hygienist. I have been advised by my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employees, agents and assignees to contact me via email, text messaging, and to my cellular devices.

Financial Policy

Payment is expected and will be collected at the time of service. I understand that responsibility for payment of dental services in this office for myself and my dependents is mine. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to the Provider. I authorize the submission of claims without obtaining my signature on each claim submitted. Any payment that is returned will be subject to a $20 bank charge fee.

Cancellation Policy

To provide the best care for our patients we request a 48-hour minimum notice to cancel or change a scheduled appointment. The more time we are allowed affords us the opportunity to offer that appointment to another patient. If an appointment is canceled within the 48-hour window we reserve the right to charge a $40.00 late cancellation fee. We pride ourselves on respecting your time, and we ask that you do the same. If you are more than 15 minutes late for an appointment, we reserve the right to ask you to reschedule the appointment.

I have read and understand these policies of Lone Tree Family Dentistry.

X_____ _____

Signature of Patient, Parent, or Guardian Date

Records Transfer Request

To: _____

Name of Doctor or Practice

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I hereby authorize the release of my dental x-rays, chart and history or copies of such to:

Lone Tree Family Dentistry
Dr. Kelly Freeman
10455 Park Meadows Drive
Suite 101
Lone Tree, CO 80124
303-790-0234

Please email records to: lonetreefamilydentistry@yahoo.com

Date: _____

Print Patient Name: _____

Signature (Patient, Parent or Guardian) : _____