



562 Castle Pines Parkway, Suite C-8•Castle Rock, CO 80108
720-457-1982•www.castlepinesdentalgroup.com

Patient Information

Name: Last First Middle
E-Mail Address: Gender: Male Female
Cell Phone: Home Phone: Work Phone:
Home Address: Street City State Zip
Date of Birth: Social Security Number: Driver's License or ID Number:

Responsible Party Information (If Patient is a Dependent)

Name: Last First Middle
Relationship to Patient: E-Mail Address:
Cell Phone: Home Phone: Work Phone:
Home Address: Street City State Zip
Date of Birth: Social Security Number: Driver's License or ID Number:

Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: Last First Middle
Primary Policy Holder's Date of Birth: Primary Policy Holder's SS/ Member ID Number:
Primary Policy Holder's Employer:
Insurance Company Name: Group Number: Insurance Company Phone:
Insurance Company Address: Street City State Zip

Emergency Contact Information

Local Friend or Relative not Living With You: Emergency Contact Phone:
Emergency Contact Address: Street City State Zip

Getting to Know You

Why did you select our office? Whom May we thank for referring you?
Is another member of your family already a patient with our practice?
When was your last dental visit?
When was the last time you had complete dental x-rays taken? Have you ever had any teeth removed?
How long have these teeth been missing?
How Have these teeth been replaced? Bridge Partial Denture Implants They have not been replaced

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

DATE

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? _____

15. Name and phone number of your primary care physician _____

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

Castle Pines Dental Group 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 Castle Pines Dental Group. 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

Castle Pines Dental Group 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 \$500.00 or more. The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. All Smiles Dental Group 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 to 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

Castle Pines Dental Group makes an effort to see patients on time in order to give patients the care they deserve. Therefore, we ask that you **please give 48 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge a cancellation fee of \$50.00 in the event of two (2) or more missed appointments lacking 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 Castle Pines Dental Group's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____