3715 Bloomington St., Suite 160•Colorado Springs, CO80922
719-599-0665•www.allsmilesdentalgroup.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:_____________________
MM / DD / YYYY

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:_____________________
MM / DD / YYYY

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: _____-____-______
MM / DD / YYYY
Primary Policy Holder's Employer:____Rank:__________

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:

❑ Heart Disease or Attack	❑ Ulcers	❑ HIV Positive (AIDS)
❑ Tuberculosis (TB)	❑ Shortness of Breath	❑ Hepatitis A (Infectious)
❑ Asthma	❑ Hepatitis B (Serum)	❑ High Blood Pressure
❑Rheumatic Fever	❑ Liver Disease	❑ Heart Murmur/Mitral Valve
❑ Scarlet Fever	❑ Diabetes	❑ Bruise Easily
❑ Artificial Heart Valve	❑ Thyroid Disease	❑ Drug Addiction
❑ Heart Pacemaker	❑ Chemotherapy (Cancer, Leukemia)	❑ Hemophilia
❑ Heart Surgery	❑ Arthritis	❑ Cold Sores or Fever Blisters
❑ Artificial Joint	❑ Cortisone Medication	❑ Epilepsy or Seizures
❑ Stroke	❑ Glaucoma	❑ Nervousness
❑ Kidney Trouble	❑ Pain in Jaw Joints	❑ 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?____

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

All Smiles 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 All Smiles 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

All Smiles 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 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

All Smiles Dental Group makes an effort to see patients on time in order to give patients they 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 All Smiles Dental Group's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: ____ Date: _________________