All Smiles Dental Group
Family & Dentist Dental Practice

3715 Bloomington Street, Suite 160, Colorado Springs, CO 80922
www.allsmilesdentalgroup.com • 719-599-0665

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

HEALTH HISTORY

Name: ______________________________ Date: ____________________

Birth Date ____________ Height __________ Weight __________ Age ________ Gender: ☐ M ☐ F

Please list all medical problems you are currently being treated for: ____

____

____

Please list all of your previous surgeries: ____

____

____

Please list any drug, food or latex allergies: ____

____

____

Please list your current medications: including aspirin or any other over the counter medications: ____________________

____

____

DO YOU HAVE, OR HAVE YOU EVER HAD....

☐Yes ☐No Chest pain
☐Yes ☐No Heart attack
☐Yes ☐No Irregular heart beat
☐Yes ☐No Pacemaker/defibrillator
☐Yes ☐No Heart murmur
☐Yes ☐No Angioplasty/bypass
☐Yes ☐No High blood pressure
☐Yes ☐No Heart valve replacement
☐Yes ☐No Asthma
☐Yes ☐No Shortness of breath
☐Yes ☐No Emphysema/COPD
☐Yes ☐No Sleep apnea

☐Yes ☐No Tuberculosis
☐Yes ☐No Tobacco use
☐Yes ☐No Diabetes
☐Yes ☐No Liver disease
☐Yes ☐No Kidney disease
☐Yes ☐No Thyroid disease
☐Yes ☐No Rheumatic fever
☐Yes ☐No Immune system problems
☐Yes ☐No Hepatitis/jaundice
☐Yes ☐No Cancer
☐Yes ☐No Chemotherapy
☐Yes ☐No Radiation therapy

☐Yes ☐No Bleeding/blood clot problems
☐Yes ☐No Anesthetic problems
☐Yes ☐No Epilepsy/seizures
☐Yes ☐No Glaucoma/eye problems
☐Yes ☐No Ulcers/gastric reflux
☐Yes ☐No History of alcohol or drug abuse
☐Yes ☐No Currently pregnant/nursing
☐Yes ☐No Hip/knee/joint replacement
☐Yes ☐No Blood thinners
☐Yes ☐No Bone density medication
☐Yes ☐No Require antibiotics prior to surgery

DENTAL HISTORY (PLEASE CHECK ALL THAT APPLY):

☐ Routine care only ☐ Orthodontics ☐ Jaw/tooth trauma ☐ TMJ problems ☐ Jaw surgery
☐ Gum disease ☐ Cancer ☐ Mouth sores ☐ Dental implants ☐ Dentures

Please list anything else about your medical or dental history we should know: ____________________________________

____

____

______________________________ ______________________
Signature-Patient/Guardian Dr's initials

UPDATED:____________________ **DATE:** ____________________

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 $300.00 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 24 hours notice if you are unable to keep your scheduled appointment**. **We reserve the right to charge a $50.00 cancellation fee for lack of 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: ______________