

BOULDER HOLISTIC DENTISTRY

Name _____ Birthdate _____ Home Phone _____
Home Address _____ Cell Phone _____
City _____ Zip _____ Work Phone _____
Workplace _____ Occupation _____
E-Mail Address _____ Emergency Contact _____
Whom may we thank for referring you? _____ Emergency Phone _____

DENTAL HISTORY

What is the purpose of your visit? _____
Are any teeth sensitive to hot, cold, sweets or pressure? _____ yes no
Can you chew food satisfactorily? _____ yes no
Do you clench, grind or grit your teeth? _____ yes no
Do you get pain in your jaw near your ears? _____ yes no
Do you get headache, earache, neck or back pain? _____ yes no
Are you happy with the appearance of your teeth? _____ yes no
Do you use dental floss or other hygiene aids regularly? _____ yes no
Have you had dental X-rays taken in the last two years? _____ yes no

Please check if you have had:

_____ root canal treatment _____ extractions _____ canker or other sores
_____ periodontal treatment (gums) _____ broken jaw _____ trench mouth (ANUG)
_____ orthodontic treatment (braces) _____ head injury _____ oral tumor or growth

MEDICAL HISTORY

Who is your physician? _____ Phone _____
Are you in good health? _____ yes no
Are you under a physician's care for any problem? _____ yes no
When was your last physical exam? _____
Have you ever had a serious illness or operation? _____ yes no
Do you take any medication now, or have you in the last year? _____ yes no
If yes, what? _____
Have you had any adverse reaction to penicillin, codeine,
"novocaine" or any other drugs? _____ yes no
Women: Are you, or might you be, pregnant? _____ yes no
Are you nursing? _____ yes no
Have you gone through menopause? _____ yes no

Please check if you have had:

_____ asthma _____ hepatitis _____ AIDS/HIV
_____ allergies _____ blood transfusion _____ digestive problems
_____ allergy to metals or jewelry _____ epilepsy or seizures _____ excessive bleeding
_____ diabetes _____ thyroid condition _____ easy bruising
_____ high blood pressure _____ kidney disease _____ benign tumor
_____ heart disease _____ respiratory disease _____ malignant tumor, cancer
_____ chest pain _____ joint replacement _____ radiation treatment

SIGNATURE _____ **DATE** _____

Financial Registration

Patient's Name _____

Payment is due at the time of service:

- Cash or check at the time of service – receive 5% discount for full payment.
- Credit card at the time of service – We take Visa, Master Card, Discover, and American Express.
- Other payment arrangements must be made in advance.

How we handle dental insurance: We will be happy to do the paperwork for insurance submission. We prefer that you pay for care at the time of service, and receive reimbursement from your insurance. (They usually pay you faster than us!) If you need to have us bill your insurance first, please provide us with a credit card number to guarantee your copayment.

Please be advised that dental insurance coverage varies widely, and the companies' notions of "usual, customary and reasonable" fees also vary widely. This office cannot be responsible for the level of benefits provided by your company.

Insured person: With dental insurance, this is the employee, or person to whom the policy is issued. (Not the dependent.) *All fields are required:*

Insured Person's Name _____ **Employer** _____

Insured Person's Member ID # _____ *or* **Soc Sec #** _____

Insurance company _____ **Group #** _____

Address _____ **Phone#** _____

Patient's relationship to insured person _____

Statement of permission and financial responsibility

By signing below, I give permission to Dr. Koral and Dr. Mustian to perform necessary dental procedures. The nature, purpose and risks of all such procedures will be explained.

By signing below, I acknowledge that I am responsible for all charges arising from services provided. I understand that, unless other arrangements are made, payment in full is due at the time services are rendered. All balances over 60 days past due will be subject to interest at the rate of 1.5% per month, or may be charged in full to my credit card. If the account is turned over to collection, I agree to pay all costs of collection, including attorney's fees.

Privacy: I have read and received a copy of the Boulder Holistic Dentistry privacy policy.

Responsible Party:

SIGNATURE _____ **DATE** _____