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
_____ periodontal treatment (gums)
_____ orthodontic treatment (braces)
_____ extractions
_____ broken jaw
_____ head injury
_____ canker or other sores
_____ trench mouth (ANUG)
_____ 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
_____ allergies
_____ allergy to metals or jewelry
_____ diabetes
_____ high blood pressure
_____ heart disease
_____ chest pain
_____ hepatitis
_____ blood transfusion
_____ epilepsy or seizures
_____ thyroid condition
_____ kidney disease
_____ respiratory disease
_____ joint replacement
_____ AIDS/HIV
_____ digestive problems
_____ excessive bleeding
_____ easy bruising
_____ benign tumor
_____ malignant tumor, cancer
_____ radiation treatment

SIGNATURE _____ **DATE** _____

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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** _____