Boulder Holistic Dentistry

Medical History

Who is your physician?_____ Phone:_____

Are you under a physician's care for any problem?	**Yes**	**No**
Are you in good health?	**Yes**	**No**
When was your last physical exam?	**Yes**	**No**
Have you ever had a serious illness or operation?	**Yes**	**No**
Are you taking any medications now, or have you in the last year?	**Yes**	**No**

If yes, what?_____

Have you had any adverse reactions to Penicillin, Codeine, "Novocaine" etc.?	**Yes**	**No**
Women: Are you, or might you be, pregnant?	**Yes**	**No**
Are you nursing?	**Yes**	**No**
Have you gone through menopause?		

Please check if you have or have had:

Asthma_____
Metal or Jewelry allergy_____
High blood pressure_____
Heart Disease_____
Chest pain_____
Allergies_____
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_____
Diabetes_____

SIGNATURE_____ **DATE**_____

303-443-4984
3450 Penrose Place Suite 120 Boulder, CO 80301

Boulder Holistic Dentistry

Medical History and Registration

Name:_____ Birthdate:_____ Home Phone:_____

Cell Phone: _____ Home Address:_____

City: _____ Zip Code: _____ Email: _____

Workplace:_____ Occupation: _____

Emergency Contact Name: _____ Phone: _____

Relationship to Patient: _____

Whom may we thank for referring you?_____

What is the purpose of your visit?_____

Dental History (please circle yes or no)

Are any teeth sensitive to hot, cold , sweets or pressure?	**Yes**	**No**
Can you chew food satisfactorily?	**Yes**	**No**
Do you clench or grind, your teeth?	**Yes**	**No**
Have you been told you snore?	**Yes**	**No**
Have you ever been diagnosed with Obstructive Sleep Apnea?	**Yes**	**No**
Do you get pain in your jaw near you 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_____ Broken Jaw_____

Head Injury_____ Canker or other sores_____ Trench Mouth (ANUG)_____

Oral Tumor Growth_____ Periodontal Treatment (Gums)_____

Orthodontic Treatment (Braces) ___

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing our rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm your appointments?	YES	NO
May we leave a message on your answering machine at home or by cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: (PLEASE PRINT NAME) _____

Signature: _____ Date: _____

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www.boulderholisticdentistry.com

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OFFICE POLICES

Financial Policy: Payments are expected to be made at the time of service, unless other arrangements have been made ahead of time. We do require all patients to have a card on file which we will collect at the time of your appointment.

Insurance Policy: Our office is not in network with any insurance companies. If you have insurance, we can submit a claim on your behalf for you to be reimbursed directly from your insurance company. We cannot gruantee reimbursement from your insurance company, as out of network coverage varies widely.

Cancellations: We require 48-business hours notification to change or cancel an appointment without incurring a charge. Appointments that are missed, cancelled or rescheduled inside of the 48-business hour window will incur a charge of 50% of the scheduled services. Our office is open Monday through Thursday from 9:00am to 5:00pm.

Please sign below stating that you have read and agreed to these terms as a patient of Boulder Holistic Dentistry.

Printed Name:_____

Signature:_____ **Date:**_____

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Financial Responsibilities Form

Payment is due at time of service:

We accept cash, check, credit and debit cards

Patient Name: _____

How we handle insurance: We are happy to handle the paperwork for insurance claim submission. We do require that you pay for care at the time of service, then you will receive reimbursement from your insurance company.

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 insurance company.

Primary: this is the employee, or person to whom the policy is issued (Not the dependent), also known as the Insured Person.

Name: _____ Date of Birth: _____

Insurance Company: _____ Employer: _____

Member ID #:_____ Or Social Security:_____

Group #: _____ Payer ID #: _____

Insurance Company Phone:_____

Address for Dental Claims: _____

Patients Relationship to Primary: _____

Statement of Permission and Financial Responsibility

By signing below, I give permission to Boulder Holistic Dentistry to perform necessary dental procedures. The nature, purpose and risks of all such procedures will be explained. 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 of service. **All missed or rescheduled appointments outside of the 48-business hour window may result in a fee of 50% of scheduled services.**

Responsible Party: _____ Date:_____

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