Boulder Holistic Dentistry

Name _____ Birthdate _____ Home Phone _____

Cell Phone _____ Preferred Contact number _____ May we leave a message on voice mail? ___

Home Address _____ Email_____

City_____ Zip_____

Workplace _____ Occupation _____

In case of emergency, notify: _____ Emergency Phone _____

Whom may we thank for referring you? _____

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
Have you been told you snore? _____	yes	no
Have you every been diagnosed with Obstructive Sleep Apnea? ____	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** _____

BOULDER HOLISTIC DENTISTRY

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, Mastercard, Discvoer 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 _____ Emplyer _____

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 Boulder Holistic Dentistry 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 if I choose, have received a copy of the Boulder Holistic Dentistry privacy policy.

Responsible Party_____ Date_____