Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Today's Date ______________

Patient Information (CONFIDENTIAL)

Name ______________ SS # ______________ Birthdate ______________

Home Phone ______________ Cell Phone ______________

Address ______________ City ______________ State ________ Zip ________

Email ______________

Emergency Contact ______________ Relationship ______________ Phone ______________

Patient's or Parent/Guardian's Employer ______________ Work Phone ______________

Spouse or Parent/Guardian's Name ______________ Employer ______________ Work Phone ______________

Whom may we thank for referring you? ______________ ☐ Friend/Family ☐ Current Patient ☐ Ins. Co. ☐ Other

Responsible Party (If not the same as above, please fill out completely.)

Person Responsible for Account ______________ Relationship to Patient ______________

Birthdate ______________ SS # ______________

Address ______________ Home Phone ______________

Email ______________ Cell Phone ______________

Employer ______________ Work Phone ______________

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of Insured ______________ Relationship to Patient ______________

Birthdate ______________ SS# ______________ Date Employed ______________

Name of Employer ______________ Union or Local # ______________ Work Phone ______________

Insurance Company ______________ Group # ______________ Policy/ID # ______________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ______________ Relationship to Patient ______________

Birthdate ______________ SS# ______________ Date Employed ______________

Name of Employer ______________ Union or Local # ______________ Work Phone ______________

Insurance Company ______________ Group # ______________ Policy/ID # ______________

Over Please

Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________________

	Yes	No
1. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________	☐	☐
2. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
3. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No
4. Are you under medical treatment now?	☐	☐
5. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
6. Are you taking any medication(s) including non-prescription medicine? Over-the-counter?	☐	☐
Are you taking any osteoporosis medication/cancer medication?	☐	☐
If yes, what medication(s) are you taking? ______________		
7. Have you ever taken Fen-Phen/Redux?	☐	☐
8. Do you use tobacco?	☐	☐
9. Do you use controlled substances?	☐	☐
10. Are you wearing contact lenses?	☐	☐

11. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ______________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________________ Date of Last Exam ______________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Aspen Dental Group to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments ____

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______________ Signature ______________ Date ______________

At Aspen Dental Group, we believe that you deserve the best care possible for your dental health. Our practice is owned and operated by Dr. Heath W. Jones. We are a family-oriented practice and understand the 3 most important values we can strive to provide our patients: Quality, Cost, and Convenience. We provide a full-service, state-of-the art dental practice. In addition to Family dentistry, we offer the latest technologies in Cosmetic, Preventive, and Restorative Dentistry. Our exceptional and experienced staff partner with our patients to provide the healthiest, most beautiful smiles dentistry can offer. From the moment you step into our practice, until the moment you complete treatment, we want you to be comfortable and relaxed.

We currently bill all insurance plans but are providers for the following: Anthem Complete or Grid +, Delta Dental Premier, Paramount (fka:Dental Health Options). Although we can maintain computerized histories of payment by a given company, they do change therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know more accurate insurance information, we will be happy to file a “pre-authorization” with your insurance company prior to treatment. This does delay treatment but will give you a more precise out-of-pocket figure directly from your insurance company.

We bill your insurance as a courtesy. If insurance does not pay within 90-days, Aspen Dental Group reserves the right to request payment in full for services from you. You are then responsible to collect the insurance funds that are due to you. Your insurance is a legal contract between you and your insurance company. Our office is not and can not be a part of that contract. Whether you have insurance or not, ultimately you are responsible for all charges incurred in our office. Any debt not paid may be turned over to a collection agency. By signing below, you are agreeing to pay for collection costs and any legal fees incurred in our attempt to collect your owed debt.

Aspen Dental Group requires payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, Debit, Cash, and Checks. Please note: Returned checks are subject to a $30.00 returned check fee and any future appointments can only be paid with cash or credit card.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you’ve always wanted. If there is anything we can do to make your visits here more pleasant, please don’t hesitate to ask one of our staff members.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO ASPEN DENTAL GROUP. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA) POLICIES WERE PRESENTED.

PRINT: ________________________________ SIGN: ____

DATE: ___________________

BISPHOSPHONATE MEDICATION UPDATE

Patient's
Name____
Last First Middle Initial Date of Birth

In order to update your medical record, it is important for us to know if you have ever received a type of medication known as Bisphosphanate. These medications are used in the treatment and prevention of osteoporosis, high blood calcium due to malignancy and bone disease associated with breast cancer, prostate cancer and multiple myeloma. This information will assist us in providing your dental care.

Please circle **Yes or No** for any of the following medications that you are currently taking **or** have taken in the past.

Brand Name	Generic Name	Circle One
Actonel	Risedronate	Yes No
Aredia	Pamidronate	Yes No
Bonefos	Clodronate	Yes No
Didronel	Ibandronate.	Yes No
Fosamex	Etidronate	Yes No
Fosamax Plus D	Alendronate	Yes No
Skelid	Tiludronate	Yes No
Zometa	Zolendronic Acid	Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's/Guardian's Signature
Date

Dentist's Signature_____________________________ Date