

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.

Patient Information (CONFIDENTIAL)

Today's Date _____

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			Yes	No	
1. Are you allergic to or have you had any reactions to the following?				4. Are you under medical treatment now?				
Local Anesthetics (e.g. Novocain)				5. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?				
Penicillin or any other Antibiotics				If yes, please explain _____				
Sulfa Drugs				6. Are you taking any medication(s) including non-prescription medicine? Over-the-counter?				
Barbiturates				Are you taking any osteoporosis medication/cancer medication? ...				
Sedatives				If yes, what medication(s) are you taking? _____				
Iodine				7. Have you ever taken Fen-Phen/Redux?				
Aspirin				8. Do you use tobacco?				
Any Metals (e.g. nickel, mercury, etc.)				9. Do you use controlled substances?				
Latex Rubber				10. Are you wearing contact lenses?				
Other (please list) _____				11. Do you have or have you had any of the following?				
		Yes	No			Yes	No	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

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

		Yes	No			Yes	No
1. Do your gums bleed while brushing or flossing?				8. Do you have frequent headaches?			
2. Are your teeth sensitive to hot or cold liquids/foods?				9. Do you clench or grind your teeth?			
3. Are your teeth sensitive to sweet or sour liquids/foods?				10. Do you bite your lips or cheeks frequently?			
4. Do you feel pain to any of your teeth?				11. Have you ever had any difficult extractions in the past?			
5. Do you have any sores or lumps in or near your mouth?				12. Have you ever had any prolonged bleeding following extractions?			
6. Have you had any head, neck or jaw injuries?				13. Have you had any orthodontic treatment?			
7. Have you ever experienced any of the following problems in your jaw?				14. Do you wear dentures or partials?			
Clicking				If yes, date of placement _____			
Pain (joint, ear, side of face)				15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?			
Difficulty in opening or closing				16. Do you like your smile?			
Difficulty in chewing							

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 _____

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, Dental Health Options, United Healthcare, Cigna, Principal, Dentemax, and Medicaid. 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. If you are in need of an extended finance option, we also work with CareCredit Healthcare Financing, who offers up to 6 months "same as cash" payment plan. Just ask one of the patient services staff for an application.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hour notice to avoid a \$35/hour cancellation fee. We reserve the right to dismiss any patient from the office who abuses this policy.

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 Bisphosphonate. 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.

<u>Brand Name</u>	<u>Generic Name</u>	<u>Circle One</u>	
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