

In order to provide the best treatment possible, please fill out the following as accurately as you can. If you have any questions, don't hesitate to ask ☺



3600 E Alameda Ste #220 Denver CO 80209
303-975-6987 www.ascentdental.com

Patient Information

Date _____ Patient Name _____ Name you wish to be called _____
Male Female Date of Birth _____ Age _____ Single Married Separated Divorced Widowed
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
Email _____ Best way to reach you during business hours _____
Social Security # _____ Employer _____ Occupation _____

IN CASE OF AN EMERGENCY PLEASE CONTACT:

Name _____ Phone _____ Relationship to patient _____
Whom may we thank for referring you _____

Insurance Information

Subscriber Name _____ Relationship to patient _____
Subscriber Birth Date _____ Subscriber Social Security # _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Insurance Phone _____
Group # _____ Insurance ID # _____

Handle Me with Care

I gag easily	I hate the noise of the drill
I feel out of control when in the dental chair	I don't like cotton in my mouth
I feel uncomfortable with what's said about my dental hygiene	I don't want metals used in my mouth
I am very uncomfortable about needles	Please respect my time
I can't tolerate the sound of the scraping noise	I don't like wearing a dental dam
I don't like the feel of the ultrasonic cleaner	I want to know the cost up front
I have health problems that we need to discuss	
I have difficulty listening & remembering what I'm told in the dental chair	
I need to know what is going on each step of the way during treatment	
My teeth are very sensitive (Please inform doctor if it is specific area)	
Pain relief is a top priority to me	

Other: _____

Dental History

Previous Dentist _____ Phone _____ Last Exam _____

Bleeding Gums?	Y N	Pain in your teeth?	Y N
Sensitivity to Cold?	Y N	Frequent sores in or	
Sensitivity to Sweets?	Y N	near mouth?	Y N
Frequent Headaches?	Y N	Experienced pain/discomfort	
Clinch or Grind Teeth?	Y N	in your jaw joint?	Y N
Dry Sockets after		Received Oral Hygiene	
extractions?	Y N	instruction?	Y N
Orthodontic treatment?	Y N	Are you happy with your	
Head, Neck or Jaw Injuries?	Y N	smile?	Y N

Further explanation of Dental conditions: _____

Ascent Dental Group uses dental photographs for both clinical and educational purposes I agree that Ascent Dental Group may use my photographs, without my name, for any clinical or educational purposes.

Patient or guardian signature

Date

Medical History

Patient Name _____ Date _____

Physician _____ Phone _____ Last Exam _____

Are you currently under medical treatment? Y N

Have you been hospitalized for a serious illness in the within the last 5 years? Y N

Are you currently taking any medication? Y N
If yes, please list:

Are you allergic to or had a reaction to any of the following:

Local Anesthetic	Y N
Penicillin or other antibiotics	Y N
Sulfa Drugs	Y N
Barbituates	Y N
Sedatives	Y N
Iodine	Y N
Aspirin	Y N
Codeine	Y N
Metals (nickel, mercury..etc)	Y N
Latex Rubber	Y N

Are you taking Phen-Fen or biophosphates? Y N

Do you use tobacco? Y N

Cigarettes? Y N

Pipe or Cigar? Y N

Smokeless? Dip or Chew? Y N

Do you use controlled substances? Y N

Do you drink alcohol? Y N

Other: _____

Women Only:

Are you pregnant or may be pregnant? Y N

Are you nursing? Y N

Are you taking oral contraceptives? Y N

Do you have, or have you had any of the following:

High Blood Pressure Y N

Heart Attack Y N

Rheumatic Fever Y N

Swollen Ankles Y N

Fainting/Seizures Y N

Asthma Y N

Epilepsy/Convulsions Y N

Leukemia Y N

Diabetes Y N

Kidney Disease Y N

AIDS or HIV Y N

Thyroid Problems Y N

Heart Disease Y N

Cardiac Pacemaker Y N

Heart Murmur Y N

Back Problems Y N

Anemia Y N

Emphysema Y N

Physiological Treatment Y N

Cancer Y N

Arthritis Y N

Joint Replacement/Implant Y N

Hepatitis/Jaundice Y N

Sexually Transmitted Disease Y N

Stomach Problems/Ulcers Y N

Chest Pains Y N

Easily Winded Y N

Stroke Y N

Hay Fever/Allergies Y N

Tuberculosis Y N

Radiation Therapy Y N

Glaucoma Y N

Recent Weight Loss Y N

Liver Disease Y N

Heart Troubles Y N

Respiratory Problems Y N

Mitral Valve Prolapse Y N

Other: _____

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 by providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to my child or myself during the periods of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group benefits otherwise payable to me. **I understand that my dental insurance**

carrier may pay less than the actual bill for services and agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient or guardian signature

Date

Ascent Dental Group Polices

Children

Parents/Guardians need to remain in the building while the child is being treated if the child is under 18 years old. Ascent Dental will not be a third party to divorce and will not bill a second parent for any percentage. Parents are welcome in the treatment area, however, it remains attending doctor's decision if parent is asked to wait in waiting room. Studies have shown that children exhibit better behavior when parent is not in the treatment area, and again this is the doctor's decision. Be assured that we take every step to make your child's dental experience positive, which will carry through for the rest of their life.

Accident

If you are being treated as a result of an accident, you must inform the dentist and staff before of insurance or benefits of any kind that are to be applied. Fees will be billed to you at usual and customary fees. You will be responsible for your account. Ascent Dental will not be a third party to any accident claims and will not bill to any other entity.

Patients without Insurance, or coverage of any kind

Patients without insurance or coverage of any kind are expected to pay for services rendered. We accept payments in the form of personal checks, cash and all major credit cards. We also offer payment plans in our office. If this is needed, please ask about our financing options.

Patients with Insurance Coverage

As a courtesy to our patients, we are glad to help you obtain the appropriate benefit from **your** insurance company. However, it is the **responsibility of the patient** to understand & be aware of the benefits covered and/or those benefits not covered. **Procedures not listed in the benefit booklet are the responsibility of the patient.** Any portion not covered/paid by insurance must be paid by the patient. **We do not bill out secondary insurance nor do we coordinate any secondary insurance benefits.** We will do our best to obtain the maximum benefit payment from your insurance, but will not let your insurance tell us what treatment is best for you. Due to insurance limitations, new technologies may not be covered and will be an out of pocket expense.

Broken Appointments

If you need to reschedule or cancel an appointment, we do require that you give 24 hours notice. This allows us enough time to try and fill your appointment time. **BROKEN OR FAILED APPOINTMENTS LESS THAN 24 HOURS NOTICE WILL BE CHARGED A \$50 CANCELLATION FEE. NO EXCEPTIONS.** Our office will make every effort to place a courtesy call and remind you of your appointment. For this reason it is important to keep us updated with changes in phone number, address and email address. Ultimately you are responsible for your appointment.

Account Balances

There will be a **5% finance charge** on balances left over 60 days. If left over 90 days, the account will be turned over to a collection agency. By signing at the bottom, the patient agrees to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% annum on all such amounts outstanding. There will also be a \$50 service charge on all returned checks and additional charges for cost of collections.

I HAVE READ THE ABOVE AND UNDERSTAND THE POLICIES OF ASCENT DENTAL GROUP

Patient or guardian signature

Date

Dental Health Testing Necessary for Proper Care

Dental Fluorescence Oral Cancer Detection

Oral Cancer risk factors include tobacco use, frequent and/or excessive alcohol consumption, a compromised immune system, past history of cancer, and the presence of the HPV virus. When oral mucosal cancer is detected by the human eye, it is usually in the later stages, giving it a poor prognosis. We can make a difference by using the latest cancer screening technology, direct fluorescence visualization. **We highly recommend this test if you are a smoker or an ex-smoker.** This exam is recommended every 6 months to a year.

_____ **YES**, I accept a fluorescence cancer screen for \$25

_____ **NO**, I refuse and understand the risk involved

Remineralization Therapy

Fluoride varnishes and amorphous calcium phosphate, a relatively new preventive treatment, can be used to strengthen teeth, reduce and restore early stage cavities. This treatment is recommended with every cleaning.

_____ **YES**, I accept remineralization for \$25

_____ **NO**, I refuse remineralization therapy and understand the risk involved.

_____ **I accept both a fluorescence cancer screen and remineralization therapy for \$35**

I understand that by signing the HIPPA consent, I authorize Ascent Dental to use and disclose my protected health information.

Patient or Guardian Signature

Date