



Thank you for visit/interest. We strive to provide you with the finest possible dental care. To allow us to meet your oral healthcare needs, please fill out the form completely.

3600 East Alameda Suite 220 Denver CO, 80209

If you need any assistance, please feel free to ask.

Patient Information (Confidential)

Name _____ Male Female

How do you wished to be addressed? _____

Date of Birth _____ Age _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Best way to communicate with you during business hours? _____

Check Appropriate: Minor Single Married Divorced Widowed Separated

If Student, Name of School College _____ City _____ State _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Secondary contact (if one) _____ Phone _____

Guarantor Information (Person Responsible for Account)

Name of person responsible for the account _____ Relationship to patient _____

Address _____ Home Phone # _____

Drivers License # _____ Birth date _____ Financial Institution _____

Employer _____ Work Phone _____ S.S# _____

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Cash Personal Check Credit Card Dental Credit I wish to discuss offices payment policy

(Payment is due in full at each appointment)

Insurance Information for Guarantor

Named of Insured _____ Relationship to Patient _____

Birth date _____ Soc. Sec. # _____ Dated Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Dental Insurance Company _____ Group # _____ Policy ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Secondary Dental Insurance? _____

Medical History

PATIENT'S NAME _____
Last
First
Initial

Physician _____ Office Phone _____ Date of last exam _____

Are you under medical treatment now? Y N

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

Are you taking any medications? Y N

Are you taking any herbal medicines or food supplements? If yes, please list... Y N

Are you taking Phen-Fen or biphospates? 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

Are you wearing contact lenses? Y N

Are you allergic to or have had a reaction to the following?

Local Anesthetics Y N

Penicillin or any other antibiotics Y N

Sulfa Drugs Y N

Barbituates Y N

Sedatives Y N

Iodine Y N

Aspirin Y N

Codeine Y N

Any Metals (e.g. nickel, mercury, etc.) Y N

Latex Rubber 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 Problem 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 or Implant Y N

Hepatitis/Jaundice Y N

Sexually Transmitted Diseases Y N

Stomach Troubles/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

Dental History

PATIENT'S NAME _____
Last First Initial

Patient Dental History

Name / Location of Previous Dentist _____ Date of Last Exam _____ X-rays _____

Do your gums bleed while brushing or flossing?	Y N	Have you ever experienced any of the following:		
Are your teeth sensitive to hot or cold?	Y N	Clicking	Y N	
Are your teeth sensitive to sweet or sour?	Y N	Pain (joint, ear, side of face)	Y N	
Do you bite your lips or cheeks frequently?	Y N	Difficulty in opening or closing mouth	Y N	
Have difficult extractions in the past?	Y N	Do you eat or drink five or more meals a day?	Y N	
Do you have frequent headaches?	Y N	Do you chew sugar free gum?	Y N	
Do you clench or grind your teeth?	Y N	Do you drink sweetened beverages between meals?	Y N	
Had prolonged bleeding following extractions?	Y N	Do you eat mints, candies, cookies, chips, crackers, etc. between meals?	Y N	
Have you had orthodontic treatment?	Y N	Do you drink milk or eat cheese everyday?	Y N	
Do you wear dentures or partials?	Y N	If yes, date of placement _____	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Y N
Have you had any head, neck or jaw injuries?	Y N	Do you feel pain in any of your teeth?	Y N	
Do you feel pain in any of your teeth?	Y N	Do you get frequent sores in or near the mouth?	Y N	
Do you get frequent sores in or near the mouth?	Y N	Do you like your smile?	Y N	
		Do you like the color of your teeth?	Y N	

Further Explanation of Dental conditions _____

Any other pertinent information not listed: _____

Ascent Dental Group uses photography of conditions and treatment for educational purposes. I authorize the release of my photographs of clinical conditions to be used as an educational aide.

Accepts _____ Declines _____

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 dentist to release any information including diagnosis and the records of any treatment or examination rendered to my child or me 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 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 if minor)

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (Including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment information from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a cop of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand you reserve the right to change the terms of this notice form time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclose that occurred prior to this date I revoked this consent is not in effect.

Signed this date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: Ascent Dental Group 3600 E Alameda Denver, CO 80209

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtain acknowledgement
- An Emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

ASCENT DENTAL GROUP OFFICE POLICIES

Children

Parents/Guardians need to remain in the building while the child is being treated if the child is under 18 yrs of age. Ascent Dental Group 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 doctors decision if parent is asked to wait in waiting room. Studies show, children exhibit better behavior when parent is not in treatment area, again this is the doctors decision. Be assured we take every step to make your child's dental experience positive, which will carry through for the rest of their life.

Accidents

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 can 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 third party to any accident claims and will not bill to any other entity.

Patients without Insurance or any other coverage

Patients without insurance or any coverage are requested to pay for services as rendered. We accept personal checks, cash, mastercard and visa. Fees will be discussed before work is completed.

Patients with insurance coverage

Our office will be glad to help you obtain the appropriate benefit from **your** insurance plan as a **courtesy** to you. However, it is the **sole responsibility of the patient** to be aware of **their benefits** that are covered and/or not covered. **Procedures not listed in the insurance benefit schedule are the patients responsibility and the procedure will be charged out at the usual and customary fee. Portions of the bill might not be covered by your insurance carrier and must be paid by the patient. Sometimes there is a co-payment required by you as per your insurance agreement. We will do our best to get the most treatment possible out of your insurance, but we don't let your insurance tell us what treatment is right for you. Insurance usually will not cover newer technology and treatments.** We do not bill out any secondary insurance companies nor do we coordinate any secondary benefits. If you are having treatment over a period of time, we would expect payment during the course of treatment. Our office staff will be glad to assist you in arranging a payment schedule.

Payment Plans

There are several options of payment plans available in the office. These are usually third party payment plans. Please feel free to ask about financing options as we can usually figure out a way to get you your treatment.

Broken Appointments

Please cancel to allow us to have enough time to allow us to get another patient in. **Broken or failed appointments (less than 24 hour notice) will be charged a 50 dollar cancellation fee. NO EXCEPTIONS.** Our office will make every effort to place a courtesy call to remind you of your appointment. For this reason, it is important you update us with changes in phone, address and email. You are ultimately responsible for your appointments.

Account balances

There will be a 3% finance charge on balances left over 30 days. If left over 90 days, the account will be turned over to a collection agency. Patient agrees to pay all court cost and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% per annum on all such amounts outstanding. There will also be a \$35.00 dollar service charge on all returned checks and additional charges for cost of collections.

Finally, be assured that we are all here to serve you with the best care. If you have any questions, again, please ask. If you have a question at anytime, contact us.

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

Signature of patient or guardian

Date

HANDLE ME WITH CARE

PATIENT'S NAME _____
Last First Initial

- I gag easy.
- I feel out of control when I am lying down in the dental chair.
- I have not been to the dentist for a long time, and I feel uncomfortable about what you say about my teeth and dental hygiene.
- Pain relief is a top priority for me.
- I don't like shots (Or I have had a bad reaction to shots).
- Please tell me what I need to know about my mouth in order to make an informed decision.
- My teeth are very sensitive. (Please inform the doctor if it is in a specific location)
- I don't like the sound of the tool that makes picking and scraping noise.
- I don't like the feel of the ultrasonic cleaner.
- I don't like cotton in my mouth.
- I don't like wearing a rubber dam (can be known as a dental dam).
- I hate the noise of the drill.
- Please respect my time, I don't want to be left sitting.
- I want to know the cost up front. No money surprises please.
- I have difficulty listening and remembering what I hear when sitting in a dental chair.
- I have health problems and questions that we need to discuss.
- I need to know what is going on each step of the way during treatment.
- I don't want any metals used as restorative material in my mouth.

Other: _____

