FLORENCE FAMILY DENTISTRY

PATIENT'S DENTAL & MEDICAL HISTORY

NAME: ____________________ BIRTHDATE: _____/_____/_____

REASON FOR THIS VISIT: ____________________

DATE OF LAST DENTAL VISIT: ____________ WHAT WAS DONE: ____________

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE: ____________________

PREVIOUS DENTIST (NAME & LOCATION): ____________________

WHEN WAS YOUR LAST SET OF COMPLETE XRAYS: ____________ OF WHICH TEETH: ____________

HOW OFTEN DO YOU BRUSH YOUR TEETH: ________ HOW OFTEN DO YOU FLOSS YOUR TEETH: ________

IS YOUR DRINKING WATER FLUORIDATED: ____ YES ____ NO

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS........	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS........	☐	☐
DO YOU FEEL PAIN IN ANY OF YOUR TEETH......	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH........	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES........	☐	☐
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........	☐	☐
DO YOU HAVE FREQUENT HEADACHES........	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH........	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY........	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH........	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH........	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)........	☐	☐
HAVE YOU EVER WORN A BITE PLATE OR OTHER APPLIANCE........	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST........	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS........	☐	☐
DO YOU WEAR DENTURES OR PARTIALS........	☐	☐
IF YES, DATE OF PLACEMENT ____________		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS........	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD IT BE? ____________________

____

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 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 DIRECILY 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.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR: ____________________ **DATE:** ________

DOCTOR'S COMMENTS: ____________________

____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORIANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
ARE YOU IN GOOD HEALTH?	☐	☐
HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
DATE OF YOUR LAST PHYSICAL EXAM: ____		
PHYSICIAN'S NAME: ____		
ADDRESS: ____		
PHONE #: ____		
ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS	☐	☐
IF YES, PLEASE EXPLAIN: ____		
ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE... IF YES, PLEASE EXPLAIN: ____		
HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
DO YOU BRUISE EASILY	☐	☐
HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	☐	☐
HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
HAVE YOU EVER TAKEN FOSAMAX, NONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES	☐	☐
HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LEVITRA IN THE LAST 24 HOURS	☐	☐
DO YOU USE TOBACCO	☐	☐
DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
ARE YOU WEARING CONTACT LENSES	☐	☐
DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	☐	☐
DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐
EXPLAIN: ____		
FOR WOMEN ONLY:		
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES OR SLEEPING PILLS, ASPIRIN	☐	☐
IODINE	☐	☐
ANY MEIALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐
LATEX / RUBBER	☐	☐
OTHER: ____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐

FLORENCE FAMILY DENTISTRY

PATIENT INFORMATION (CONFIDENTIAL)

NAME: ____ DATE: _____/_____/_____

ADDRESS: ________________________________ CITY: __________ STATE: _____ ZIP: ________

EMAIL: ____________________ CELL PHONE: ______________ HOME PHONE: ______________

SS#/SIN: ____________________ BIRTHDATE: __________________

CHECK APPROPRIATE STATUS: ___ MINOR ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED

IF COLLEGE STUDENT, FT/PT, NAME OF SCHOOL: ____________________ CITY: ________ STATE: ____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER: ____________________ WORK PHONE: __________

BUSINESS ADDRESS: ____________________________ CITY: __________ STATE:_____ ZIP: ______

SPOUSE OR PARENT'S/GUARDIAN'S NAME: ______________ EMPLOYER: ________ WORK PHONE: ________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

EMERGENCY CONTACT: ____________________ PHONE: ____________ RELATIONSHIP: ____________

EMERGENCY CONTACT: ____________________ PHONE: ____________ RELATIONSHIP: ____________

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT ABOVE)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: __________________ RELATION TO PATIENT: ________

ADDRESS: ____ HOME PHONE: __________

DRIVER'S LICENSE #: __________________ BIRTHDATE:______________ SS#/SSI: ______________

EMPLOYER: ____ HOME PHONE: __________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ____ YES ____ NO

INSURANCE INFORMATION

POLICY HOLDER NAME: ______________________________ RELATION TO PATIENT: ____________

BIRTHDATE: ____________ SS#/SIN: __________________ DATE EMPLOYED: ______________

NAME OF EMPLOYER: ____________________ UNION/LOCAL#: ________ WORK PHONE: ____________

EMPLOYER ADDRESS: ______________________________ CITY: __________ STATE:_____ ZIP: ______

INSURANCE NAME: __________________ TEL#: __________ GRP#: __________ POLICY#: ________

INS. CO. ADDRESS: ______________________________ CITY: ____________ STATE:_____ ZIP: ______

HOW MUCH IS YOUR DEDUCTIBLE: ______ HOW MUCH HAVE YOU USED: ________ MAX ANNUAL BENEFIT: ________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ____ YES ____ NO (IF YES, COMPLETE THE INFO BELOW)

INSURANCE NAME: __________________ TEL#: __________ GRP#: __________ POLICY#: ________

INS. CO. ADDRESS: ______________________________ CITY: ____________ STATE:_____ ZIP: ______

HOW MUCH IS YOUR DEDUCTIBLE: ______ HOW MUCH HAVE YOU USED: ________ MAX ANNUAL BENEFIT: ________

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR: ________________________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Florence Family Dentistry
David L. Smith, D.M.D., P.C

SECTION A: PATIENT GIVING CONSENT

Name: ____

Date of Birth: _______/_______/_______

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. David L. Smith, D.M.D.
Telephone: (719) 784-3935
Address: 100 S. Pikes Peak Ave, Florence, CO 81226
Fax: (719) 784-4686

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I (PRINT NAME), ____, have had full opportunity to read and consider the
contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: ____

Date: _______/_______/_______

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:
Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

FINANCIAL POLICY

Florence Family Dentistry
David L. Smith, D.M.D., P.C

We would like to keep our fees as low as possible. Therefore, **payment will be due on the day services are rendered.** For your convenience, we accept **cash, personal check, VISA, and MasterCard**. For more extensive dental treatment plans, **CareCredit** is also available.

Special note for patients with Insurance!

We strive to help our patients maximize their dental plan benefits. To minimize your out-of-pocket expense at the time of your visit, we will submit for direct payment of your dental plan benefits. We do ask that *you* pay your estimated payment portion and deductible (if applicable) on the day of treatment.

Upon receipt of your company's dental plan payment, we will refund any credit or bill the balance to you. Balances and credits of less than $5.00 will be kept on account. Please understand that our services are provided to you, the patient, and not your insurance company.

Please pay close attention to your available insurance benefits. If you exceed the set annual maximum in this, or any other office, you are ultimately responsible for the remaining balance. Therefore, you, and not the insurance company, are responsible for any unpaid balance on your account.

Please note that our office will apply a monthly finance charge of 1.5% (annual percentage rate of 18%) on all account balances over 30 days. All accounts that are submitted for collection to an agency will be subject to an additional charge equal to 35% of account balance.

If you do not show up for a scheduled appointment, a $50 fee will be automatically charged to you. If scheduled appointments are repeatedly cancelled and/or rescheduled without 24 hours notice a $50 fee will be assessed to your account.

I have read and agree to the financial terms for this office.

Patient Signature: ______________________________________ Date: _______/_______/_______

If patient is a minor,
Parent or Guardian Signature: ____________________________ Date: _______/_______/_______

I Understand Dr. Smith and/or his employees will be taking intra-oral pictures. These pictures are, but not limited to, teeth, tissue and lips. I give my permission for Dr. Smith to use these pictures for educational and advertisement purposes. Pictures used will not have any personal information attached or advertised.

(initial) _______ Yes, I will allow Dr. Smith to use my pictures
(initial) _______ No, Thank You