

**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: \_\_\_\_\_

**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

DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING .....	<b>YES</b>	<b>NO</b>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY.....	<b>YES</b>	<b>NO</b>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN IN ANY OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER WORN A BITE PLATE OR OTHER APPLIANCE.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS.....	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE).....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING.....	<input type="checkbox"/>	<input type="checkbox"/>			
DIFFICULTY IN CHEWING.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE FREQUENT HEADACHES.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>			

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 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.

**SIGNATURE** OF PATIENT OR PARENT/GUARDIAN IF MINOR: \_\_\_\_\_ **DATE:** \_\_\_\_\_

DOCTOR'S COMMENTS: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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 IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

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

	YES	NO		YES	NO
<b>ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:</b>			FAINING OR DIZZY SPELLS.....	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE.....	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION.....	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS.....	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS ALLERGIES.....	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS, ASPIRIN.....	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM.....	<input type="checkbox"/>	<input type="checkbox"/>
IODINE.....	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT.....	<input type="checkbox"/>	<input type="checkbox"/>
ANY MEIALS (E.G., NICKEL, MERCURY, ETC.)....	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER.....	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER.....	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER: _____			TUBERCULOSIS.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</b>			PERSISTENT COUGH.....	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD.....	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA).....	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR.....	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA CHEST PAIN.....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES.....	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH.....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER.....	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY.....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS.....	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE.....	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS.....	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM.....	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS.....	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS.....	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE.....	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>
STROKE.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY.....	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE.....	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT.....	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS.....	<input type="checkbox"/>	<input type="checkbox"/>
HIVES OR SKIN RASH.....	<input type="checkbox"/>	<input type="checkbox"/>	HYPOGLYCEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>

**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

