PONDEROSA FAMILY DENTAL
14991 E Hampden Ave
Suite 370
Aurora, Co 80014
303-693-1215

Patient Information

Name: ____
Last First Middle

E-mail Address ______________________ Gender: Male _____ Female _____

Cell Phone (___) ____________ Home Phone: (___) ____________ Work:(___) ____________

Home Address: ____
Street City State Zip

Date of Birth ___/___/____ Social Security # ____-____-____ Driver's License or ID # ____________
MM/DD/YYYY

Responsible Party Information (If Patient is a Dependent)

Name: ____
Last First Middle

Relationship to Patient: ____________________ E-mail Address ______________________

Cell Phone (___) ____________ Home Phone: (___) ____________ Work:(___) ____________

Home Address: ____
Street City State Zip

Date of Birth ___/___/____ Social Security # ____-____-____ Driver's License or ID # ____________
MM/DD/YYYY

Emergency Contact Information

Local Friend or Relative not Living with You: ______________________________
Circle One
Emergency Phone: ____________________

Getting to Know You

Are you okay with an Adorable Golden Retriever in the office? ____ Yes ____No

Why did you select our office? ____

Whom May we Thank for referring you? ______________________________

Is another member of you family already a patient with our practice? Yes No
Circle One

Family Member:
____

When was your last Dental visit? __________ When was the last complete Dental x-rays taken? __________

Have you ever had any teeth removed? __________ How long have these teeth been missing?
____

How Have these teeth been replaced? ____Bridge ____Partial ___Denture ___Implants ____They have not been replaced.

What did you like about your last dental visit or team? ______________________________

What did you NOT like? ______________________________

FOR ALL PATIENTS

I authorize Ponderosa Family Dental to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the Doctor chooses and employs such assistance as he/she deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the Doctor and/or his/her staff.

I agree to pay for all services rendered by this office.

Signature: ______________________________ **Date:** __________

SIGNATURE OF RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	DATE

MEDICAL HISTORY – Please Answer ALL Questions

Name:______________________________ **Date of Birth:**_______________ **Age:**_______

Gender: Male / Female **Height:** _______ft. ______in. **Weight:**___________ lbs.

Primary Care Physician:______________________________ **Phone/Contact:**_______________

1. Do you consider yourself a healthy person? .... ❑ Yes ❑ No
2. Have you been under the care of a medical doctor during the past two years? .... ❑ Yes ❑ No
   If yes, for what reason?______________________ Est. Last Physical Exam Date:____________
3. Do you consider your teeth, gums and mouth to be healthy and problem free? .... ❑ Yes ❑ No
4. Do your gums bleed at any time? .... ❑ Yes ❑ No
5. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? .... ❑ Yes ❑ No
   If yes, please list.______________________________
6. Have you ever had excessive bleeding requiring special treatment? .... ❑ Yes ❑ No
7. Women: Are you or might you be pregnant? .... ❑ Yes ❑ No Estimated Due Date______________
8. Check any and all of the following which you have a history of or currently under treatment for:

❑ Heart Disease or Attack ❑ Ulcers ❑ HIV Positive (AIDS)
❑ Tuberculosis (TB) ❑ Shortness of Breath ❑ Cancer or Tumor
❑ Asthma ❑ Hepatitis (circle: Type A, B or C) ❑ High Blood Pressure
❑ Rheumatic Fever ❑ Liver Disease ❑ Heart Murmur/Mitral Valve
❑ Scarlet Fever ❑ Diabetes ❑ Bruise Easily
❑ Artificial Heart Valve ❑ Thyroid Disease ❑ Drug Addiction
❑ Heart Pacemaker ❑ Chemotherapy (Cancer, Leukemia) ❑ Hemophilia
❑ Heart Surgery ❑ Arthritis ❑ Cold Sores or Fever Blisters
❑ Artificial Joint ❑ Cortisone Medication ❑ Epilepsy or Seizures
❑ Stroke ❑ Glaucoma ❑ Nervousness
❑ Kidney Trouble ❑ Pain in Jaw Joints ❑ Psychiatric Treatment

Do you have or have history of any surgery, disease or medical condition not listed on this form? .... ❑ Yes ❑ No

Please list:____

9. List all Prescription Medications you are taking at this time. ❑ None ______________________
10. Do you use any type of tobacco product regularly? .... ❑ Yes ❑ No
11. Do you use or have you ever used recreational drugs? .... ❑ Yes ❑ No
12. Do you clench or grind your teeth? .... ❑ Yes ❑ No
13. Do you or have you been told you snore loudly (enough to bother others)? .... ❑ Yes ❑ No
14. Are you aware or have you been told you stop breathing or are choking while sleeping? .... ❑ Yes ❑ No
15. Do you often feel tired, fatigued or can't stay awake during the daytime? .... ❑ Yes ❑ No
16. Do you currently use or have been diagnosed to need a CPAP breathing machine to sleep? .... ❑ Yes ❑ No

Signature: ______________________________ **Date:** ____________________

Ponderosa Family Dental

HIPAA Release Form

Patient Name: ______________________________________ **DOB:** ________________

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

____ **Spouse** ____

____ **Child(ren)** ____

____ **Other** ____

____ **Information is not to be released to anyone.**

Messages

Please Call:

____ **My Home**

____ **My Work**

____ **My Cell Number** ____

If unable to reach me:

___ **You may leave a detailed message.**

___**Please leave a message asking me to return your call.**

____ **Do not leave a message.**

Signature; ____ **Date:** _______________

Office Financial Policy

Insurance: As a courtesy to our patients, we will bill your insurance. Please bear in mind that there are many different plans and policies. Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you, your employer, and the insurance company. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. Ultimately, you are responsible for all charges. Some, and perhaps all, of the services provided may not be covered by your insurance company, in which case you will be responsible for the charges for these services. Although we gather as much information as possible regarding your insurance, it is ultimately your responsibility to know which services your insurance policy covers.

Payment: Payment is due when service is provided. If you have insurance, we will collect from you the amount **estimated** as your initial responsibility. Any amount not paid by your insurance, in accordance with your policy, is your responsibility and is due upon receipt of a statement from our office. If payment from your insurance company is not received within 60 days from the date of service, you may be expected to pay the balance in full. Balances carried over 90 days are considered delinquent and will be subject to a monthly interest of 1.5% (APR 18%). If payment is delinquent, you will be responsible for payment of a 30% collection fee and additional court costs associated with the recovery of the monies due on the account. We accept Cash, Checks, Visa, Master Card, American Express and Discover.

_______________________________________ ____________________

Signature of Patient, Parent or Guardian Date

____

Print Name