Ponderosa
FAMILY DENTAL

Patient Information

Name:______________________________

Email Address: ____________________ **Gender:** M / F / Other ________

Cell Phone: (___)__________ **Home Phone:** (____)__________

Work: (___)__________

Home Address: ______________________________

Date of Birth ___/___/_____ **Social Security Number #**_____-_____-_______

Driver's License or ID# ________________

Responsible Party Information (If Patient is a Dependent)

Name: ______________________________

Email Address: ____________________ **Gender:** M / F / Prefer not to answer

Cell Phone: (___)__________ **Home Phone:** (____)__________

Work: (___)__________

Home Address: ______________________________

Date of Birth ___/___/_____ **Social Security Number #**_____-_____-_______

Driver's License or ID# ________________ **Insurance Carrier:** ________________

Emergency Contact

Local Friend or Relative not living with You: ______________________

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? ______________________________

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Whom may we thank for referring you? ____

Is another member of your family already a patient with our Practice? Yes / No

Family Member Name: ____

When was your last Dental Visit? ______________

When was the last complete Dental X-Rays Taken? __________________________

Have you ever had any teeth removed? Yes / No

If yes, How long have these teeth been missing? ________________

How have these teeth been replaced? ___Bridge ____Partial ____ Denture ____Implant They have not been replaced

What did you like about your last dental office? ______________________________________

What did you NOT like about your last dental office? __________________________________

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 necessary. I also understand that prior to treatment, full explanation of the procedure(s) involved will be provided by the Doctor and/or his/her staff.

I agree to pay for all services rendered by this office. If insurance doesn't pay in full, I am aware that I will be billed for the remainder of the fee of the procedure.

Signature ____**Date**______________

Confidential Medical History

Patient Name:______________________________ Birthdate________________ Today's date_____________

Name and Address of your medical Physician:____
____ Date of last physical__________________________

PLEASE CIRCLE CORRECT ANSWER:

YES NO Are you under the care of a physician? If yes, for what? ______________________________

YES NO Any major illness or surgery? If yes, please be specific; include date_____________________

YES NO Are you taking any drugs/medications (e.g., cortisone, aspirin, vitamins, anticoagulant, etc..)?
____

YES NO Any recent weight gain or loss?

YES NO Do you use any form of tobacco products (cannabis oil, marijuana, vaping, cigarettes, chew, cigars, etc?) ____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? If yes, please describe under remarks.

YES	NO	
___	___	AIDS or AIDS related disease (HIV)
___	___	Alcoholism
___	___	Allergies or Drug reactions____________
___	___	Anemia
___	___	Arthritis or Autoimmune disease
___	___	Asthma
___	___	Bleeding problems
___	___	Breathing problems (shortness of breath)
___	___	Emphysema
___	___	Cancer/Tumor (treatment, chemo, surg.,)
___	___	Diabetes Type:________
___	___	Dry Mouth/Dry Eyes
___	___	Endocrine disturbances (Thyroid, etc.)
___	___	Epilepsy, Convulsions, Seizures
___	___	Fainting
___	___	Frequent headaches
___	___	Hay Fever/Environmental Allergies
___	___	Heart Trouble, Damage, Murmur
___	___	High Blood Pressure
___	___	Chest Pains
___	___	Artificial Heart Valves-date___________
___	___	Artificial Joints: date_______________
___	___	PRE-Medication Required for Heart/Joints
___	___	Rheumatic Fever
___	___	Herpes
___	___	Hepatitis: Type___ Liver Disease/Jaundice
___	___	Kidney or Urinary problems
___	___	Psychological or emotional problems

YES	NO	
___	___	Radiation
___	___	Sinusitis
___	___	Snoring ___ Snoring Device Y N
___	___	Sleeping Difficulties
___	___	Spina Bifida
___	___	Stomach or Digestive problems (ulcers)
___	___	Stroke
___	___	Swelling of Feet or Ankles
___	___	Tuberculosis
___	___	Venereal Disease

ANY UNDISIREABLE REACTIONS TO:

YES	NO	
___	___	Local Anesthetics (Novocaine, etc)
___	___	Oral surgery or Tooth extractions
___	___	Penicillin or other Antibiotics: ____________________
___	___	Other Drugs or Medicines ____________________
___	___	Latex Allergy

WOMEN:

YES	NO	
___	___	Are you taking Birth Control pills?
___	___	Are you now pregnant? ____months
___	___	Are you nursing?

REMARKS:_____________________________
____
____
____
____
____

Patient Signature______________________________ Date_______________. PFD Staff initial________

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HIPPA 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:__________

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Appointment Cancellation Policy: Please understand that appointment times are limited. If you must cancel your appointment, we respectfully request 48-hour notice. Missed appointments, or appointments cancelled without 48-hour notice, will incur a fee of $75 for every 90 minutes.

Examples:

- You have a one-hour appointment booked; you will be charged $75.
- You have a three-hour appointment booked; you will be charged $150.

Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call us at 303-693-1215 between office hours, email us at info@ponderosafd.com or texting the appointment portal link sent to your cell phone.

If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 48 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge $75 for each 90-minute block you have reserved.

In the event of two (2) documented instances of cancellations, the patient will be flagged for "pre-paid only" The patient will be required to pay in full for all work scheduled.

In the event of three (3) documented instances of cancellations, the patient may be subject to dismissal from the practice.

Patient Name: ______________________________

Patient Signature: ______________________________**Date:** __________

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Informed Consent for Local Anesthesia

I understand that my dental treatment may require the use of a local anesthetic for pain control.

I understand that a local anesthetic may consist of different medications that are injected into the cheek, jaw or gum area. These drugs may include, lidocaine, prilocaine, mepivacaine, bupivacaine, articaine, or others.

I understand that local anesthetics may contain a "vasoconstrictor" like epinephrine; antioxidants, such as sulfites or methylparaben for preservation of the solutions; sodium hydroxide, and sodium chloride. I understand that local anesthetics will cause a section of my mouth to become numb, with the numbness lasting up to several hours. I know that while my mouth is numb I must be careful not to bite my lips or tongue.

Local anesthetics are among the most common drugs used in a dental office.

- Complications and side effects are rare, but may include, among others not listed on this sheet:
- Swelling, bruising, or soreness at the injection site.
- A blood filled swelling called hematoma, can form when a needle used during an injection hits a blood vessel.
- Temporary numbness outside of the mouth making an eyelid or mouth "droop".
- Temporary rapid heartbeat.
- Damage to the nerves resulting in temporary or possibly permanent numbness or tingling of lips, chin, tongue or other areas.
- Severe and possible life threatening allergic reactions necessitating emergency care.

I understand that if I have uncontrolled high blood pressure, uncontrolled thyroid problems, angina, or have recently had a heart attack, I will inform my dentist without fail as these conditions have caused complications for persons receiving local anesthesia. I will also inform the dentist of any prescription or over-the-counter medications I am taking as these may interact with local anesthetics. I understand my dentist's recommendation of local anesthetic for all the dental procedures that require adequate pain control, risks of the local anesthetics, any alternatives, and risks of these alternatives, including consequences of doing nothing.

This consent for local anesthetics remains valid every time I seek any treatment in this office.

I have had all of my questions answered and have not been offered any guarantees.

Patient Name ____

Patient or Guardian Signature________________________________Date_____________

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 90 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 sent to collections which you will be responsible for a 30% collection fee and any additional costs associated with the recovery of the monies due on the account.

We accept cash, Checks, Visa, Master Card, American Express and Discover. **Please note all credit cards are subject to an additional 3% surcharge. There is no additional charge for debit or FSA/HAS cards.

Care Credit is also an option and fees may apply.

______________________________ ______________

Signature Date

____

Print Name