PATIENT REGISTRATION

PATIENT INFO *(PLEASE PROVIDE US WITH A COPY OF YOUR PICTURE ID AND INSURANCE CARD)* DATE ___________________

FIRST NAME____ LAST NAME ____

PREFERRED NAME____ GENDER ___________________________

ADDRESS____

CITY/STATE/ZIP ____

HOME PHONE __________________________________ CELL PHONE __________________________________ WORK _______________________________

SSN _______________________________________ BIRTH DATE ________________________________ MARITAL STATUS _____________________________

EMAIL ____

☐ I WOULD LIKE TO RECEIVE CORRESPONDENCE BY EMAIL
☐ I WOULD LIKE TO RECEIVE CORRESPONDENCE BY TEXT MESSAGE

☐ EMPLOYED ☐ STUDENT ☐ RETIRED ☐ MILITARY

EMPLOYER ____ OCCUPATION ____

PATIENT IS: RESPONSIBLE PARTY OR POLICY HOLDER (Circle one or both)

Whom may we thank for inviting you to our practice? ____

RESPONSIBLE PARTY

FIRST NAME____ LAST NAME ____

ADDRESS____ CITY/STATE/ZIP ____

HOME PHONE __________________________________ CELL PHONE __________________________________ WORK _______________________________

SSN _______________________________________ BIRTH DATE ________________________________ MARITAL STATUS _____________________________

PRIMARY INSURANCE INFORMATION

NAME OF INSURED ____RELATIONSHIP TO INSURED ____________________________

INSURED SSN ____ INSURED DATE OF BIRTH ____

INSURANCE COMPANY ____ EMPLOYER GROUP____

INSURANCE ADDRESS____ CITY/STATE/ZIP ____

INSURANCE PHONE ____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED ____RELATIONSHIP TO INSURED ____________________________

INSURED SSN ____ INSURED DATE OF BIRTH ____

INSURANCE COMPANY ____ EMPLOYER GROUP____

INSURANCE ADDRESS____ CITY/STATE/ZIP ____

INSURANCE PHONE ____

MEDICAL HISTORY

Although we primarily treat the area in and around your mouth, your mouth is the entrance to the entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for filling out to the best of your knowledge.

Are you under a physician's care now? If yes, whom? ____

Have you ever been hospitalized or had a major operation? If yes, please explain ____

Have you ever had a serious head or neck injury? If yes, please explain ____

Are you taking any medications, pills, or drugs? ☐ YES ☐ NO If yes, please list below.

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate medications? ☐YES ☐NO

Do you use tobacco? ☐ YES ☐ NO If yes: Type of tobacco? _________________ Frequency? _________________ Number of years used? _________

Do you use controlled substances? ☐ YES ☐ NO

Women: Are you pregnant or trying to get pregnant? ☐YES ☐ NO Nursing? ☐ YES ☐NO Taking oral contraceptives? ☐YES ☐NO

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐Acrylic ☐ Metal ☐Latex ☐ Sulfa Drugs

Other, please explain ____

Do you have or have you had any of the following?

☐ AIDS/HIV Positive	☐ Excessive Bleeding	☐ Low Blood Pressure
☐ Alzheimer's Disease	☐ Excessive Thirst	☐ Lung Disease
☐ Anaphylaxis	☐ Fainting Spells/Dizziness	☐ Osteoporosis
☐ Anemia	☐ Frequent Cough	☐ Pain in Jaw Joints
☐ Angina	☐ Frequent Diarrhea	☐ Parathyroid Disease
☐ Arthritis/Gout	☐ Frequent Headaches	☐ Psychiatric Care
☐ Artificial Heart Valve	☐ Glaucoma	☐ Radiation Treatments
☐ Artificial Joint	☐ Hay Fever	☐ Recent Weight Loss
☐ Asthma	☐ Heart Attack/Failure	☐ Rheumatic Fever
☐ Blood Disease	☐ Heart Murmur	☐ Rheumatism
☐ Blood Transfusion	☐ Heart Pacemaker	☐ Scarlet Fever
☐ Breathing Problem	☐ Heart Trouble/Disease	☐ Shingles
☐ Bruise Easily	☐ Hemophilia	☐ Sickle Cell Disease
☐ Cancer	☐ Hepatitis A	☐ Sinus Trouble
☐ Chemotherapy	☐ Hepatitis B or C	☐ Stomach/Intestinal Disease
☐ Chest Pains	☐ Herpes	☐ Stroke
☐ Cold Sores/Fever Blisters	☐ High Blood Pressure	☐ Swelling of Limbs
☐ Congenital Heart Disorder	☐ High Cholesterol	☐ Thyroid Disease
☐ Cortisone Medicine	☐ Hives or Rash	☐ Tonsilitis
☐ Diabetes	☐ Hypoglycemia	☐ Tuberculosis
☐ Drug Addiction	☐ Irregular Heartbeat	☐ Tumors or Growths
☐ Easily Winded	☐ Kidney Problems	☐ Ulcers
☐ Emphysema	☐ Leukemia	☐ Venereal Disease
☐ Epilepsy or Seizures	☐ Liver Disease	

Comments:

____

____

____

Please List Current Medications and Dosage (attach list if necessary):

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian ____ Date ___________________________

Your Name: ____ Date: ______________________

We would like to take this opportunity to welcome you to our office and thank you for giving us the opportunity to support you in your dental health. We would like to provide you with exactly the type of treatment you want. Answering the following questions will allow us to give you the type of care you are looking for.

1. I think my present state of health is:
   - o Excellent
   - o Average
   - o Poor

2. My mouth is:
   - o Very comfortable
   - o Moderately comfortable
   - o Uncomfortable

3. The appearance of my mouth is:
   - o Very Good
   - o Satisfactory
   - o Not what I would like it be

4. Regarding my natural teeth:
   - o I want to do anything to keep them
   - o I will do only what is absolutely necessary
   - o I don't care if I keep them

5. I would like my treatment to:
   - o Be the best possible in health and appearance
   - o Be very conservative
   - o Be only what is needed to stay out of pain

6. If you could change one thing about the health or appearance of your mouth, what would it be?

   ____

How long has it been since you have seen a dentist? _____________________________
When was your last COMPLETE dental exam? _________________________________
When was your last CLEANING? ____
When was your last FULL MOUTH X-RAYS? _________________________________
Are you having dental problems now? ___________ Explain: ____
Do you wear removable dentures or partials? _________________ Are you happy with these? _____________
Are you apprehensive about dental treatment? __________________________________
Have you ever had any gum treatments? ____
Do your gums bleed, feel tender, or are irritated? _________________________________
Do you regularly use dental floss? ____
Are you aware of grinding or clenching your teeth? ______________________________
Do you have headaches, earaches or neck aches regularly? _______________________
Have you ever worn braces or other orthodontic devices on your teeth? _______________

Rank the following in order in which it would KEEP YOU from having the NECESSARY DENTAL TREATMENT
(1 being the greatest concern and 4 being not concerned)

Fear of Pain___ Cost of Treatment___ Lack of Concern___ Missing Work___

ADULT AIRWAY QUESTIONNAIRE

Your Name: ____ Date: ______________________

AGE: __________ SEX: M / F HEIGHT: __________ WEIGHT: __________

Do you breath through you mouth? During the day? Y / N At night? Y / N

Do you frequently get a dry throat or non-productive cough? Y / N

Do you have any nasal allergies? Y / N

Do you snore or have you been told you snore while sleeping? Y / N

Do you stop breathing or pause breathing while sleeping? Y / N

Do you wake up fatigued? Y / N

Do you have trouble falling asleep? Y / N

Do you have trouble staying asleep? Y / N

Do you have morning tension or migraine headaches? Y / N

Do you easily get tired and fall asleep during the day? Y / N

Do you clench or grind your teeth during the night? Y / N

Do you clench or grind your teeth during the day? Y / N

Do you have any facial pain? Y / N

Do you take sleep aids before going to bed? Y / N

Do you usually drink alcohol before going to bed? Y / N

Do you suffer from hypertension (high blood pressure)? Y / N

Have you been diagnosed with:
- Chronic Fatigue Syndrome? Y / N
- Irritable Bowel Syndrome? Y / N
- Fibromyalgia? Y / N
- Temporomandibular Syndrome (TMJD)? Y / N

Do you use a cPAP? Y / N Currently? Y / N In the past? Y / N

Do you use oxygen at night? Y / N

GENERAL CONSENT FOR DENTAL PROCEDURES

Patient Name: ____ Date of Birth: ____________

REGARDING MY MEDICAL HISTORY:

________ (INITIALS) I certify that the answers to the health and dental questionnaires are accurate and correct to the best of my knowledge. I understand that a change in medical or dental condition(s), or a change in medication(s) may affect my dental treatment. I agree to notify Dr. Johnson or any associates or employees of any changes that may occur.

REGARDING GENERAL CONSENT TO DENTAL PROCEDURES:

________ (INITIALS) I do hereby authorize and request the performance of dental services by Dr. Johnson, associates, or employees they may designate, and the use of any procedures Dr. Johnson or staff may deem necessary or advisable to maintain my dental health, the dental health of any minor or other individual for which I am legally responsible for. I understand that treatment options will be explained to me so that I may make an informed decision regarding my dental care or the dental care of a minor or dependent.

REGARDING ANESTHESIA AND MEDICATION:

________ (INITIALS) I understand that anesthetics may be used for therapeutic, diagnostic, or treatment purposes. I authorize for myself, and any minor or other individual for which I have legal responsibility, the administration of any anesthetics, or analgesics, including without limitation, therapeutic and/or other pharmaceutical agents (including those related to restorative, palliative, therapeutic, or surgical treatment) that may be deemed appropriate by Dr. Johnson, associates or employee. I understand that antibiotics, anesthetics, analgesics and other medications may cause complications and reactions including without limitation allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I also understand that additional complication may include, but are not limited to, pain, swelling, bruising, temporary limited opening, hematoma, cardiac stimulations, reduction in the effectiveness of birth control, muscle soreness, temporary or permanent numbness, and local infections. I further understand that on occasion anesthesia may be prolonged and in very rare cases, permanent. I understand that I may also request that no anesthetic be used at the time of treatment for myself, or any minor or dependent that I am legally responsible for.

REGARDING DENTAL TREATMENT:

________ (INITIALS) I understand that any treatment plans presented, along with the fees outlined, could change depending on the extent of dental pathology and the time elapsed since the initial examination. I understand that once the treatment phase has begun, complications may arise that dictate additional procedures or treatments not limited to root canals, crowns, extractions and/or implants. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I authorize Dr. Johnson to make any and all changes and additions as necessary. I further understand that any changes in treatment will be explained to me so I may make an informed decision regarding my dental care or the care of a minor or dependent.

________ (INITIALS) I understand that a more extensive treatment plan than originally discussed, including but not limited to root canal therapy, crowns, and/or surgical therapy (extraction and implants) may be required due to additional conditions discovered during or after dental treatment.

CONSENT: *I have had the opportunity to have all my questions answered by Dr. Johnson, associates or employees thereof, and I certify that I understand English. My signature below signifies that I understand that the recommended treatment and anesthesia will be explained to me together with the know risks and complications associated with such treatment. I hereby give my consent for any dental procedures, anesthesia and treatment thereof by Dr. Johnson and associates or employees.*

Patient/Guardian Signature: ____ **Date:** ____________

Printed Patient/Guardian Name: ____

Relationship to Patient: ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ______________________________, have received a copy of this office's Notice of Privacy Practices and allow the office to share information about my treatment with the following individuals (please give specific names, i.e. family members, other dentists, physicians, insurance companies, attorneys, etc.):

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

__________________________________ _________________
Print Patient Name Date

____
Signature of Patient or Responsible Party

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but it could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining the acknowledgement
- o Other (please specify)

HIPAA AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION FOR TEACHING, MARKETING, AND EXTERNAL COMMUNICATION

I, ______________________________, authorize Affinity Dental Arts to use photos, xrays, and/or other dental information for educational purposes.

By initialing below, I authorize the use and/or disclosure of the following information:
______ Still photos or video footage for use in educational lectures, educational discussions, and/or, publications.

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorize the disclosure of the protected health information as stated.
____ **Date:** _______________________________________
(Signature of patient/guardian/patient representative)

Printed Name:______________________________ **Relationship to patient:** ______________________
Declined__________________________

PAYMENT OPTIONS

We want the handling of your account to be an extension of the professional care we provide you and your family. In order to eliminate surprises and help meet your needs, we are dedicated to offering customized financial plans. Communication is important, and therefore, one of our team members will review with you your treatment, its costs, and payment options prior to reserving an appointment time. This will allow you the ability to select the treatment to be scheduled, as well as your preferred method of payment.
Full payment is due at the time of service.
We accept Cash, Check, Visa, MasterCard, Discover, and American Express

INSURANCE

As a courtesy to you, we will file all necessary documents with your insurance company the 1st business day after your appointment if you have provided us with sufficient information of your policy. As part of the financial arrangement process, our office will estimate your insurance coverage for a procedure, however, it is not possible for our office to be 100% accurate in the prediction of what your policy will cover. It is your responsibility as the patient, to familiarize yourself with your specific policy. We are an independent provider and we do not guarantee any benefits you will receive from your insurance company. Ultimately, the cost of treatment is your responsibility.

COMMITMENT

Our office is dedicated to providing exceptional overall care. We appreciate your cooperation.

I have read the Financial Alliance. I understand, accept and agree with the Financial Alliance.

____ __________
Patient Signature or Responsible Party Date

Swedish Medical Plaza
601 E. Hampden Ave., Suite 300
Englewood, CO 80113

303.788.6462
info@affinitydentalartsco.com

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient Name: ___________________________________ Date: ____________

Date of Birth: ___________________________________

Practice/Provider Name: ____

Phone: ________________________

Address: ________________________

Please send records to: ______ Affinity Dental Arts

______ Other: ____

Information Requested:

__X__ Copy of Complete Dental Chart

__X__ Copy of Dental X-rays

______ Other (e.g. models – describe) ______________________________

Purpose(s) for which information is to be used:

______ Transfer of records ______ Other ____________________________________

Authorization: *I certify that this request has been made voluntarily and that the information given above is accurate and to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.*

_______________________________________ _______________

Patient Name (print) Date

____

Patient Signature