PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other _____
Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐	Sleep Apnea	☐	☐	Cochlear Implants?	☐	☐
Coronary Stent*	☐	☐	X-Ray Treatments (Radiation)	☐	☐									

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____
History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.

PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST, M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐Yes ☐No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No

☐Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)

Card # _____ Exp. Date _____

☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

FINANCIAL POLICY

TIMBERLINE FAMILY DENTISTRY

We are pleased you have chosen Timberline Family Dentistry to provide your dental care. For your convenience, we are providing you an explanation of our payment policy.

We accept cash, personal checks, Visa, Mastercard, and Discover for payment of your account. Payment is due when treatment is rendered. Accounts over 90 days will be assessed a finance charge of 1.5% monthly (18%annually).

INSURANCE: We accept traditional insurance which have no restrictions on who the dental provider is that you elect to care for you. We do not participate in any managed care programs i.e. PPO, DMO, EPO, or HMO. As a courtesy, we will submit your insurance claims for you if you supply us with the necessary information: copy of your dental insurance card, an address to submit claims, social security number & birth date of subscriber, AND a telephone number allowing us to verify coverage. **You are still responsible for payment of your portion of treatment not covered by your insurance, including deductibles, at the time of service, If coverage is denied for any reason, you are responsible for payment of the entire balance due.**

If you do not have dental insurance, you will be expected to pay for your treatment in full at the time of service unless you have made prior financial arrangements.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for dental charges incurred, but also for 100 % of the collection costs, 100% of court costs, and 100% of attorney fees.

INSURANCE COVERAGE IS A MATTER BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT ON YOUR ACCOUNT.

NOTE: A $50 fee will be applied to your account if a scheduled dental appointment is cancelled with less than 48 hours notice. This will apply to no show appointments as well.

I have read and understand this financial policy.

_____ Date_____

Signature of accounts responsible party

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use and disclosure of my protected health information (PHI) by **Timberline Family Dentistry** for the purpose of diagnosis and treatment, payment activities and to conduct health care operations. I understand that any provider at Timberline Family Dentistry may decline to treat or continue to treat me without my consent.

I understand I have the right to revoke my consent in writing, at any time, except to the extent that Timberline Family Dentistry has taken action in reliance on this consent. Timberline Family Dentistry may decline to treat me by revoking my consent.

My "protected health information" means any health information, including demographic information collected from me and created or received by my health care providers, insurance health plans, my employer or health care clearinghouse. This PHI relates to my past, present, or future physical/mental health or condition and identifies me.

I understand I have the right to read Timberline Family Dentistry's Notice of Privacy Practices prior to signing this consent. **Timberline Family Dentistry's Notice of Privacy Practices** has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my PHI that will occur in treatment, payment activities and the health care operations of Timberline Family Dentistry. The Notice of Privacy Practices can be obtained and provided at **796 East Kiowa Avenue, Suite H12, PO Box 1169, Elizabeth, Colorado 80107. Phone 303-646-3940.**

Timberline Family Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. You may obtain a revised notice of privacy practices by calling the office to request a revised copy be mailed to you or by asking for a revised copy at your next appointment.

_____ _____

Name of Patient Date

_____

Signature of Patient or Personal Representative

_____

Relationship of Personal Representative to Patient

GENERAL DENTISTRY INFORMED CONSENT

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized.

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures or decay not detectable on xrays or intial clinical evaluation. I give my permission to Dr. Unkel/Dr. Shibilski to make any/all changes and additions as necessary.

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation with 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. If a bite discrepancy is observed after the anesthetic wears off, it is the patient's responsibility to call the office for an occlusal adjustment. I understand that significant sensitivity is a common effect after a newly placed filling and that it is my responsibility to inform the treating doctor of any prolonged discomfort.

I understand that on rare occasions a nerve parasthesia may result upon administration of local anesthetic.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I have had the opportunity to discuss with the doctor my overall health and medical history, I accept the risks of subsequent harms, if any, in hopes of obtaining the desired beneficial results of this treatment.

Signature of Patient_____ Date_____

Signature of Doctor_____ Date_____

Smile Assessment Form

Please consider each statement carefully and circle YES or NO. The doctor and members of the dental team will discuss your responses with you in confidence.

1.	I am concerned about the appearance of my teeth or my smile	YES	NO
2.	I am concerned about the whiteness/lack of whiteness of one or more of my teeth	YES	NO
3.	I am concerned about the position or angle of one or more of my teeth	YES	NO
4.	I am concerned about the shape of one or more of my teeth	YES	NO
5.	In social situations, I am sometimes embarrassed about my teeth or smile	YES	NO
6.	There are some things about my upper front teeth I would like to change	YES	NO
7.	There are some things about my lower front teeth I would like to change	YES	NO
8.	I have old fillings and/or previous dental work that is no longer satisfactory to me	YES	NO
9.	I am missing one or more of my permanent teeth	YES	NO
10.	I am interested in learning more about esthetic/cosmetic dentistry	YES	NO

We strive to provide personalized service for you. To better help in giving you the best service possible, please answer the following questions.

What is most important to you regarding your dental health?

What is most important to you regarding us as your dental team?

What is most important in your relationship with your dentist?