Mountain Shadows Dental
Creating Healthy, Beautiful Smiles

11078 Cimarron St Unit H, Firestone, CO 80504
303-485-6595

**Patient Information**

Name:

_____
Last First Middle Preferred Name (if different)

E-Mail Address: _____ Gender: Male_____ Female_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____ Driver's License or ID Number:_____
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 Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____ Driver's License or ID Number:_____
MM / DD / YYYY

**Dental Insurance Information (Please Provide a Copy of Your Card)**

Name of Primary Policy Holder:

_____
Last First Middle

Primary Policy Holder's Date of Birth: ___/___/_____ Primary Policy Holder's SS/ Member ID Number: _____
MM / DD / YYYY

Primary Policy Holder's Employer:_____Military Rank:_____

Insurance Company Name:_____ Group Number:_____ Insurance Company Phone: (____)_____

Insurance Company Address:_____
Street City State Zip

**Emergency Contact Information**

Local Friend or Relative: _____ Emergency Contact Phone: (____)_____

Emergency Contact Address:_____
Street City State Zip

**Getting to Know You**

Why did you select our office? _____ Whom May we thank for referring you?_____

Is another member of your family already a patient with our practice? _____

When was your last dental visit? _____

When was the last time you had 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

***FOR ALL PATIENTS***

**I authorize the doctor 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 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 staff. I agree to pay for all services rendered by this office.**

_____

**SIGNATURE OF RESPONSIBLE PARTY** **RELATIONSHIP TO PATIENT** **DATE**

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## HEALTH HISTORY

Name: _____ Date: _____

Birth Date _____ Height _____ Weight _____ Age _____ Gender: ☐ M ☐ F

Please list all medical problems you are currently being treated for: _____

Please list all of your previous surgeries: _____

Please list any drug, food or latex allergies: _____

Please list your current medications: including aspirin or any other over the counter medications: _____

## DO YOU HAVE, OR HAVE YOU EVER HAD....

| | | |
|---|---|---|
| ☐Yes ☐No Chest pain | ☐Yes ☐No Tuberculosis | ☐Yes ☐No Bleeding/blood clot problems |
| ☐Yes ☐No Heart attack | ☐Yes ☐No Tobacco use | ☐Yes ☐No Anesthetic problems |
| ☐Yes ☐No Irregular heart beat | ☐Yes ☐No Diabetes | ☐Yes ☐No Epilepsy/seizures |
| ☐Yes ☐No Pacemaker/defibrillator | ☐Yes ☐No Liver disease | ☐Yes ☐No Glaucoma/eye problems |
| ☐Yes ☐No Heart murmur | ☐Yes ☐No Kidney disease | ☐Yes ☐No Ulcers/gastric reflux |
| ☐Yes ☐No Angioplasty/bypass | ☐Yes ☐No Thyroid disease | ☐Yes ☐No History of alcohol or drug abuse |
| ☐Yes ☐No High blood pressure | ☐Yes ☐No Rheumatic fever | ☐Yes ☐No Currently pregnant/nursing |
| ☐Yes ☐No Heart valve replacement | ☐Yes ☐No Immune system problems | ☐Yes ☐No Hip/knee/joint replacement |
| ☐Yes ☐No Asthma | ☐Yes ☐No Hepatitis/jaundice | ☐Yes ☐No Blood thinners |
| ☐Yes ☐No Shortness of breath | ☐Yes ☐No Cancer | ☐Yes ☐No Bone density medication |
| ☐Yes ☐No Emphysema/COPD | ☐Yes ☐No Chemotherapy | ☐Yes ☐No Require antibiotics prior to surgery |
| ☐Yes ☐No Sleep apnea | ☐Yes ☐No Radiation therapy | |

## DENTAL HISTORY (PLEASE CHECK ALL THAT APPLY):

| | | | | |
|---|---|---|---|---|
| ☐ Routine care only | ☐ Orthodontics | ☐ Jaw/tooth trauma | ☐ TMJ problems | ☐ Jaw surgery |
| ☐ Gum disease | ☐ Cancer | ☐ Mouth sores | ☐ Dental implants | ☐ Dentures |

Please list anything else about your medical or dental history we should know: _____

_____ _____

Signature-Patient/Guardian Dr's initials

**UPDATED:**_____ **DATE:** _____

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Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can make you as comfortable as possible.

1. Please rate, in order of value, what is most important to you in dental care: (The most important will be #1)
   ____Preventative Care
   ____Only what is necessary at the time: cost is important
   ____Comprehensive, quality care, best looking results
   ____Other_____

2. Please rate, as in #1, what is most important to you in your relationship with a dentist.
   ____Show me what he/she is doing or planning to do so I can clearly see what is happening
   ____Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment
   ____Make sure I feel comfortable and informed at all times.

3. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)
   1 2 3 4 5 6 7 8 9 10

4. Are you concerned about: (please circle yes or no)

| | | |
|---|---|---|
| Replacing missing teeth | Yes | No |
| Eliminating any cavities | Yes | No |
| Gum disease | Yes | No |
| Bad breath | Yes | No |
| Snoring at night | Yes | No |
| Color of your teeth | Yes | No |
| Appearance of your smile | Yes | No |

5. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)
   1 2 3 4 5 6 7 8 9 10

6. When we review your treatment plan with you, would you like to know (please check one):
   ____The big picture of what needs to be done
   ____All the treatment details along the way

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## DENTAL INSURANCE POLICY

Mountain Shadows Dental proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

**Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.**

**----------PATIENT ACKNOWLEDGMENT AND AUTHORIZATION----------**

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Mountain Shadows Dental. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

## APPOINTMENT DEPOSIT REQUIREMENT

**Mountain Shadows Dental requires a minimum $50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of $500.00 or more.** The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Mountain Shadows Dental requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature: _____ Date: _____

## CANCELLATION POLICY

Mountain Shadows Dental makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 48hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge a cancellation fee of $50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: _____ Date: _____

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, _____, have had the opportunity to review Mountain Shadows Dental's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____