
Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

## 1. Personal Information

Date _____ Email _____

Birthdate _____SS# _____-_____-_____Driver's License # _____

First Name _____ Middle Initial _____ Last Name_____

Nickname _____

❒ Male ❒ Female ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Address _____

City _____State _____Zip_____

Employer _____Occupation _____

Referred by _____

## 2. Responsible Party

**Who is responsible for the account? If same as above, please check here: ❒**

Name _____

Relationship to patient: ❒ Parent/Guardian ❒ Spouse ❒ _____

Birthdate _____Driver's License # _____

SS# _____Email _____

Address _____

City _____State _____Zip_____

Employer _____Occupation _____

Work Phone _____Ext. # _____

Home Phone _____Cell Phone_____

## 3. Telephone

Home Phone _____ Work Phone _____Ext. # _____

Cell Phone_____

Where do you prefer to receive calls? ❒ Home ❒ Work ❒ Cell

## 4. Emergency Contact

In the event of an emergency, whom should we contact?

Name _____Relationship _____

Cell # _____Home # _____ Work # _____

## 5. Dental Insurance Information

**Primary Insurance**

Name of Insured _____

Relationship to Patient_____

Insured's Birthday _____

SS#_____

Employer _____

Effective Date _____

Occupation _____

Group # _____

Policy/Subscriber ID # _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

**Secondary Insurance**

Name of Insured _____

Relationship to Patient _____

Insured's Birthday _____

SS#_____

Employer _____

Effective Date _____

Occupation _____

Group #_____

Policy/Subscriber ID # _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

## 6. Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient or parent/guardian if minor Date

## 7. Financial Arrangements

**For your convenience, we offer the following methods of payment:**

PAYMENT IN FULL AT EACH APPOINTMENT.
Please check the option which you prefer.

_____Cash

_____Personal Check

_____Care Credit

_____Credit Card (Visa, MasterCard, Discover)

_____I wish to discuss the dental office's policy.

**LATE CHARGES**

If you do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

**Thank you for filling out this form completely.**

The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask – we are always happy to help.

## Office Policies & Financial Arrangements

We are committed to providing you with the best possible dental care and are pleased to discuss any and all of our professional fees at any time. Your clear understanding of the following information is very important to our professional dental relationship. If you have any questions or concerns, please ask one of our qualified team members.

**Payment Options with No Insurance Benefits –** Payment in full is due at each appointment. We offer up to 6 months 0% interest free financing available through Care Credit with credit approval. A service charge of 1.5% per month or 18% per year is applied to all balances that exceed 30 days. We also accept cash, check and most credit cards for payments.

**Payment Options with Insurance Benefits –** We will bill any insurance company, however, it is extremely important that you are familiar with your benefit plan prior to having services rendered. **It is the patient's responsibility to provide insurance plan information or we will be unable to file dental claims on your behalf.** Many insurance companies have a timely filing limit of 90 days, so failure to provide information in a timely manner may result in no payment from the insurance company.

It is important to check your dental benefit plan on a yearly basis as those benefits may have changed from a previous year. Treatment provided in another office during your current plan year may alter your copay due for services in our office. In such cases, we cannot track whether you have reached your yearly maximum benefits. **We do our best to estimate what your insurance company may pay; however, it is ultimately your responsibility and not that of High Plains Dental to know your plan.** Keep in mind; we provide an estimate of benefits and not a guarantee of payment. Your estimated portion is due at the time of service. **Once your insurance company has paid their portion, any remainder balance is due in full within 30 days.** All charges not paid by your insurance company are your responsibility, regardless of the reason for non-payment. **If your insurance company has not paid your claim within 90 days of services rendered, you will need to remit payment in full to the office.** You will be reimbursed when we receive payment from your insurance company. After 90 days, it will be the patient's responsibility to actively pursue payment from their insurance company.

**Limited Exams –** We will be happy to make an appointment for you to take care of your treatment needs. For limited exams, payment will be collected IN FULL at the time of service. Our policy is that we will see a patient for two limited exam appointments in our office and complete the recommended treatment associated with the exam. After two limited exam appointments, you must become an established patient by having a comprehensive exam and regular dental cleanings to continue being seen in our office.

**Broken Appointments/Short Notice Cancellations –** Appointments are reservations made for you, therefore, we request a 24-hour notice if you are unable to keep your scheduled appointment. We do understand that there are circumstances that come up such as weather, sickness, and car trouble when you are unable to give us 24 hours notice. Appointments are reserved exclusively for you. We appreciate your business and would like to work with you to maintain your dental health, but we also have a commitment to see our patients in a timely manner and the need to utilize our appointment times effectively. Our office has a policy of no more than three missed appointments without proper notice.

**Cell phones –** Cell phones may be used in our waiting room area only. All cell phones must be turned off or set to silent while in our operatories unless you have prior authorization from the doctor or hygienist.

**Cold Sores –** We do not treat patients with active cold sores, if you have a cold sore you should call to reschedule your appointment for a later date.

**Nitrous Oxide Gas –** Our policy on nitrous oxide gas is that we do not administer it while any of our staff are pregnant and working. We will set aside specific times for Nitrous Oxide gas administration if there are staff members that are pregnant.

**Minor Patients –** In the case of divorced or separated parents, it is your responsibility to have financial arrangements made before the treatment begins. Payment for services of minors is the responsibility of the adult accompanying the minor and is due at the time of service.

**Consent & Authorization –** I authorize dental treatment on myself or my child and agree to pay all related fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. Please indicate your understanding and acceptance of these office and financial policies by signing below.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Printed Patient Name | Patient Date of Birth | Signature of Patient/Legal Guardian | Date |

If you are filling this out for a minor, are you the person legally responsible? ❑ Yes ❑ No

## Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I can receive your Notice of Privacy Practices effective 02/01/2026 containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may withdraw or revoke my permission at any time by notifying High Plains Dental P.C. practice in writing.

In addition to phone calls, how may we confirm your appointments? Please check all that apply.

☐ Text Messages ☐ Email _____

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If YES, please name the members allowed:

_____

_____

Patient Name (Printed):_____

Relationship to Patient: _____

Signature:_____ Date:_____

---

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

# Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

*Your Name* *Relationship*

**Do you have any of the following diseases or problems:** *(Check DK if you Don't Know the answer to the the question)*

| | Yes | No | DK |
|---|---|---|---|
| Active Tuberculosis | ☐ | ☐ | ☐ |
| Persistent cough greater than a 3 week duration | ☐ | ☐ | ☐ |
| Cough that produces blood | ☐ | ☐ | ☐ |
| Been exposed to anyone with tuberculosis | ☐ | ☐ | ☐ |

***If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.***

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

| | Yes | No | DK |
|---|---|---|---|
| Do your gums bleed when you brush or floss? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ☐ | ☐ | ☐ |
| Is your mouth dry? | ☐ | ☐ | ☐ |
| Have you had any periodontal (gum) treatments? | ☐ | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatment? | ☐ | ☐ | ☐ |
| Have you had any problems associated with previous dental treatment? | ☐ | ☐ | ☐ |
| Is your home water supply fluoridated? | ☐ | ☐ | ☐ |
| Do you drink bottled or filtered water? | ☐ | ☐ | ☐ |

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

| | | | |
|---|---|---|---|
| Are you currently experiencing dental pain or discomfort? | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Do you have earaches or neck pains? | ☐ | ☐ | ☐ |
| Do you have any clicking, popping or discomfort in the jaw? | ☐ | ☐ | ☐ |
| Do you brux or grind your teeth? | ☐ | ☐ | ☐ |
| Do you have sores or ulcers in your mouth? | ☐ | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ | ☐ |
| Do you participate in active recreational activities? | ☐ | ☐ | ☐ |
| Have you ever had a serious injury to your head or mouth? | ☐ | ☐ | ☐ |

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Are you now under the care of a physician? | ☐ | ☐ | ☐ |

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

| | | | |
|---|---|---|---|
| Are you in good health? | ☐ | ☐ | ☐ |
| Has there been any change in your general health within the past year? | ☐ | ☐ | ☐ |

If yes, what condition is being treated?

Date of last physical exam:

| | Yes | No | DK |
|---|---|---|---|
| Have you had a serious illness, operation or been hospitalized in the past 5 years? | ☐ | ☐ | ☐ |

If yes, what was the illness or problem?

| | | | |
|---|---|---|---|
| Are you taking or have you recently taken any prescription or over the counter medicine(s)? | ☐ | ☐ | ☐ |

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

# Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

*(Check DK if you Don't Know the answer to the question)*

| | Yes | No | DK |
|---|---|---|---|
| Do you wear contact lenses? | ☐ | ☐ | ☐ |
| **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | ☐ | ☐ | ☐ |
| Date: _____ If yes, have you had any complications? _____ | | | |
| Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? | ☐ | ☐ | ☐ |
| Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | ☐ | ☐ | ☐ |
| Date Treatment began: _____ | | | |

| | Yes | No | DK |
|---|---|---|---|
| Do you use controlled substances (drugs)? | ☐ | ☐ | ☐ |
| Do you use tobacco (smoking, snuff, chew, bidis)? | ☐ | ☐ | ☐ |
| If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED | | | |
| Do you drink alcoholic beverages? | ☐ | ☐ | ☐ |
| If yes, how much alcohol did you drink in the last 24 hours? _____ | | | |
| If yes, how much do you typically drink i n a week? _____ | | | |
| **WOMEN ONLY** Are you: | | | |
| Pregnant? | ☐ | ☐ | ☐ |
| Number of weeks: _____ | | | |
| Taking birth control pills or hormonal replacement? | ☐ | ☐ | ☐ |
| Nursing? | ☐ | ☐ | ☐ |

**Allergies.** Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

| | Yes | No | DK |
|---|---|---|---|
| Local anesthetics _____ | ☐ | ☐ | ☐ |
| Aspirin _____ | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics _____ | ☐ | ☐ | ☐ |
| Barbiturates, sedatives, or sleeping pills _____ | ☐ | ☐ | ☐ |
| Sulfa drugs _____ | ☐ | ☐ | ☐ |
| Codeine or other narcotics _____ | ☐ | ☐ | ☐ |
| Metals _____ | ☐ | ☐ | ☐ |
| Latex (rubber) _____ | ☐ | ☐ | ☐ |
| Iodine _____ | ☐ | ☐ | ☐ |
| Hay fever/seasonal _____ | ☐ | ☐ | ☐ |
| Animals _____ | ☐ | ☐ | ☐ |
| Food _____ | ☐ | ☐ | ☐ |
| Other _____ | ☐ | ☐ | ☐ |

***Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.***

| | Yes | No | DK |
|---|---|---|---|
| Artificial (prosthetic) heart valve | ☐ | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ | ☐ |
| Damaged valves in transplanted heart | ☐ | ☐ | ☐ |
| Congenital heart disease (CHD) | | | |
| Unrepaired, cyanotic CHD | ☐ | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ | ☐ |

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

| | Yes | No | DK |
|---|---|---|---|
| Cardiovascular disease | ☐ | ☐ | ☐ |
| Angina | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Other congenital heart defects | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date: _____ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| AIDS or HIV infection | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Systemic lupus erythematosus | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Cancer/Chemotherapy/ Radiation Treatment | ☐ | ☐ | ☐ |
| Chest pain upon exertion | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes Type I or II | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. Reflux/persistent heartburn | ☐ | ☐ | ☐ |
| Ulcers | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Fainting spells or seizures | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| If yes, specify: _____ | | | |
| Sleep disorder | ☐ | ☐ | ☐ |
| Do you snore? | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| Specify: _____ | | | |
| Recurrent Infections | ☐ | ☐ | ☐ |
| Type of infection: _____ | | | |
| Kidney problems | ☐ | ☐ | ☐ |
| Night sweats | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Persistent swollen glands in neck | ☐ | ☐ | ☐ |
| Severe headaches/ migraines | ☐ | ☐ | ☐ |
| Severe or rapid weight loss | ☐ | ☐ | ☐ |
| Sexually transmitted disease | ☐ | ☐ | ☐ |
| Excessive urination | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | ☐ | ☐ | ☐ |

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

| | Yes | No | DK |
|---|---|---|---|
| Do you have any disease, condition, or problem not listed above that you think I should know about? | ☐ | ☐ | ☐ |

Please explain:

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

**FOR COMPLETION BY DENTIST**

Comments: