



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:
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Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			
Mailing Address:	City:	State:	Zip:
Date of Birth: / /	Gender:		
Occupation:			
Emergency Contact: Name:	Relationship:	Phone:	
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____			
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?			
When was your last dental exam? / /		What was done at that appointment?	
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth?	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>
Does it hurt to chew, bite or swallow?	<input type="checkbox"/>	If yes, please describe what happened and when it happened: _____	
Do your gums bleed when you brush or floss your teeth?	<input type="checkbox"/>	Have you ever had problems with dental treatment in the past?	<input type="checkbox"/>
Have you ever had periodontal (gum) treatments like scaling and root planing?	<input type="checkbox"/>	If yes, please describe what happened: _____	
Do you have, or have you ever had, any sores or growths in your mouth?	<input type="checkbox"/>	Have you ever had a reaction to, or problem with, dental anesthesia?	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	If yes, please describe what happened: _____	
Does your jaw click, pop or hurt?	<input type="checkbox"/>	Are you unhappy with your smile?	<input type="checkbox"/>
Do you have earaches or neck pains?	<input type="checkbox"/>	If yes, why? Please mark all that apply:	
Does dental treatment make you nervous?	<input type="checkbox"/>	<input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth	
Have you ever experienced any of these sleep-related breathing disorders?	<input type="checkbox"/>	<input type="checkbox"/> Other. Please describe: _____	
<input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep			
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions.			
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?			Yes No ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what medication are you taking? _____			
Are you taking any medication to treat osteoporosis or Paget's disease?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking? _____			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? _____ How many years have you been taking it? _____			
Are you taking hormonal replacements ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you use vaping products ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
How many alcoholic beverages do you have per week? _____			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally			
Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If yes, please list them here and include information about how much and how often you use each one. _____			
Do you use GLP-1 Glucagon-Like Peptide-1 medication ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
WOMEN ONLY: Are you:			
Taking birth control pills ?			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pregnant? If yes, number of weeks: _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nursing? If yes, number of weeks: _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

