



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

Parent Guidelines

Dear Parents:

You may choose whether or not you accompany your child to his/her filling appointment. Although we sense that some children do better without parents present, we are open to having you with your child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

1. Allow us to prepare your child
2. Be supportive of the practice's terminology. In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We try to avoid words that scare the child due to previous experiences. Please support us by NOT USING negative words that are often used for dental care. These include:

<u>DON'T USE</u>	<u>OUR EQUIVALENT</u>
needle or shot	sleepy juice
drill	Mr. Whistler/Mr. Bumpy
drill on tooth	clean a tooth
pull or yank tooth	wiggle a tooth out
decay, cavity	sugar bug
examination	count teeth
tooth cleaning	tickle teeth
rubber dam	raincoat
gas	magic air

This will also help you understand your child's description of the filling experience. Our intention is not to "fool" the child-- it is to create an experience that is positive. We appreciate your cooperation in helping us build a good attitude for your child!

3. Please be a silent observer, support your child with touches
 - a. This allows us to maintain communication with your child
 - b. Children normally listen to their parents instead of us and may not hear our guidance
 - c. You might have incorrect or misleading information
4. If asked to leave, be ready to immediately walk away
 - a. Many children will try to control the situation
 - b. "Acting out" is normal, but unacceptable during fillings
 - c. This is intended to "short circuit" the control attempt
 - d. We will continue to support your child at all times

These are very important ways that you can actively help in the success of your child's visit. We are confident that all will go well and hope these guidelines will help prepare you will confidence for the upcoming appointment.

Signed: _____ Date: _____

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION					
Last Name:	First Name:	Middle Name:	Nickname:		
Date of Birth: / /	Gender:				
Parent's/Guardian's Name:		Relationship to Patient:			
Email Address:					
Home Phone:	Cell Phone:	Work Phone:			
Mailing Address:	City:	State:	Zip:		
Please use an "X" to mark your answers to the following question.					
Have you (the adult) or the patient (the child) had? <input type="checkbox"/> A cough that's lasted longer than three weeks <input type="checkbox"/> A cough that produces blood <input type="checkbox"/> Active Tuberculosis					
Please bring this form to the receptionist right away if you marked "Yes" to any of these items.					
PATIENT'S DENTAL HEALTH HISTORY					
What is the reason for your visit today?					
How would you describe the patient's oral health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor					
Does the patient currently have any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____					
Is this the patient's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, when was the patient's last dental exam? _____ What was done at that appointment? _____					
When was the last time the patient had dental x-rays taken?					
Please use an "X" to mark your answers to the following questions.			Yes	No	?
Has the patient had any problem with dental treatment in the past? If yes, please describe what happened: _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient had any problems with teeth coming in or losing teeth?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient use fluoride toothpaste when brushing teeth? How often are the patient's teeth brushed? _____ time(s) per _____ At what time(s) of day are the teeth brushed? _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever worn braces or other orthodontic appliances?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had a serious injury to the head, mouth or teeth? If yes, please describe what happened and when it happened: _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient play any contact sports or participate in active recreational activities? If yes, please describe those activities here: _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What is the patient's primary source of drinking water? <input type="checkbox"/> Tap <input type="checkbox"/> Bottled <input type="checkbox"/> Filtered <input type="checkbox"/> Well					
Does the patient take fluoride supplements?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does/did the patient use a pacifier or suck his/her thumb or fingers? At what age did the patient stop breastfeeding? _____ At what age did the patient stop bottle feeding? _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever experienced any sleep-related breathing disorders? <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep					

PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

Please list the name and phone number of the patient's physician:
Doctor's Name: _____ Phone: _____
Does the patient see any medical specialists? Yes No If yes, please explain. _____

Please use an "X" to mark your answers to the following questions. Yes No ?

Is the patient currently being treated for any condition(s) or illness(es)? If yes, what is the illness and when did it start?
Has the patient ever had a serious illness? If yes, what was the illness and when did it happen?
Has the patient ever been hospitalized? When and why?
Has the patient ever been given a general anesthetic?
Has the patient ever had a blood transfusion?
Does the patient experience excessive bleeding when cut?
Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist? If so, please explain why and provide the name of the doctor making that recommendation.
Doctor's Name: _____ Phone: _____
Has the patient been diagnosed with any physical, developmental, mental or emotional conditions? If yes, please explain.
Does the patient have any genetic (inherited) conditions? If yes, please explain.
Does the patient have any speech difficulties? If yes, please explain.
How would you describe the patient's eating habits?
Is the patient up-to-date with immunizations related to childhood diseases (tetanus, measles, mumps, etc.)? Yes No
If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? Immunized Not immunized
Over the past two weeks, has the patient felt connected to the world around them? Yes No ?

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

- ADD/ADHD
- Alcohol/Drugs
- Anemia
- Arthritis
- Asthma
- Bladder problems
- Bleeding disorders
- Bone/Joint issues
- Cancer
- Cerebral Palsy
- Chicken Pox
- Chronic sinusitis
- Diabetes
- Ear aches
- Epilepsy
- Fainting
- Growth problems
- Hearing problems
- Heart Issue
- Heart Murmur
- Hepatitis
- HIV/AIDS
- Immunizations
- Kidney problems
- Liver problems
- Measles
- Mononucleosis
- Mumps
- Pregnancy (teens)
- Rheumatic Fever
- Seizures
- Sexually transmitted infection (STI)
- Sickle Cell Anemia
- Thyroid issues
- Tobacco/Vaping
- Tuberculosis
- Other: _____

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions. Yes No ?

Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications?
If yes, please list them here: _____
Is the patient taking GLP-1 Glucagon-Like Peptide-1 medication?
Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?
If yes, please list those medications and what happened when the patient took them: _____
Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.?
If yes, please describe the allergy and the reaction: _____

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. 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.

The dentist and I have talked about any questions I had about this form.
I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.
Signature of Parent/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____
Office Use Only:
 Medical Alert Premedication Allergies Anesthesia
Reviewed by: _____ Date: _____