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WELCOME

Thank you for joining our periodontal practice. We appreciate your confidence in us and we will do everything possible to provide you with the finest periodontal care. Please fill out the following pages and ask if you have any questions.

PATIENT INFORMATION

TODAY'S DATE_____

LAST NAME | FIRST | M.I. | NICKNAME

STREET NUMBER & NAME | CITY & STATE | ZIP CODE

HOME PHONE NUMBER | BUSINESS PHONE NUMBER | CELL PHONE NUMBER

EMAIL ADDRESS | SOCIAL SECURITY NUMBER | DATE OF BIRTH - AGE

FEMALE or MALE

BUSINESS NAME | OCCUPATION | SEX

REFERRED BY WHOM: (name of dentist, or friend)

EMERGENCY CONTACT

NAME | TELEPHONE | RELATIONSHIP

MEDICAL HISTORY

Personal Physician's Name:____________________________
Phone Number:___________________________
Please list any **serious medical problems** or surgeries you have had:____
____
Please list any medications that you are now taking:________
____

Do you smoke? ☐YES ☐NO Use Marijuana? ☐YES ☐NO
WEIGHT:____________ HEIGHT________________
WOMAN: Are you pregnant? ☐YES ☐NO
Taking contraceptives? ☐YES ☐NO

Do you have or have you had any of the following:

___Artificial Joints
___Artificial Heart Valve
___Circulatory Problems
___Drug/Alcohol Abuse
___Excessive Bleeding
___Heart Murmur
___High Blood Pressure
___Low Blood Pressure
___Nervous Problems
___Radiation Treatment
___Sleep Apnea
___ Anemia
___Aids/HIV+
___Cancer
___Diabetes
___Fever blisters
___Hepatitis A, B or other
___Herpes
___Kidney problems
___Panic attacks
___Rheumatic fever
___Sinus problems

Please tell us about any **current medical condition, NOT** listed above, which may possibly affect your dental treatment:____

Are you **allergic** to any of the following medications: (please check all that apply).

___Penicillin ___ Aspirin ___ Ibuprofen
___Clindamycin ___ Codeine ___ Acetaminophen
___Dental Anesthetics OTHER:_________________

DENTAL HISTORY

Family Dentist______________________________________
How long have you been a patient in that office?__________
Reason for today's visit: ____________________________
Have you ever had gum treatment? __NO __Yes
Deep cleaning? Date (YR): _____Gum Surgery Date:______

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is **my responsibility to inform this office of any changes in my medical or dental status.**

____
Signature Date

MEDICAL UPDATES

DATE	CHANGE	MEDS

Statement of Financial Policy

Please initial and sign, indicating your understanding of the following information. If you have questions, please do not hesitate to ask. It is important that you understand these specific policies of Colorado Gum Care.

_____ It is your responsibility to provide the office with current and correct insurance information. Failure to do so could result in your insurance company rejecting your claims for failure to obtain authorization or timely filing. In the event that this should happen you will be responsible for the incurred charges.

_____ We do not always know if you have a deductible, if your deductible has been met, or if you have co-insurance. It is your responsibility to know this information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible or co-insurance.

_____ If you have a co-pay or and/or estimated patient portion, you are expected to pay this when you check in for your visits. Most insurance companies assign a patient portion to recall appointments and operative visits. It is our responsibility to collect this at the time of service. We accept cash, checks, money orders, Visa, Master Card, Discover and American Express. Be prepared to pay when you check in for each visit.

_____ You will be charged a $75.00-$150.00 fee if you fail to show up for your appointment or if you cancel your appointment without proper notice.

_____We do offer financial arrangements with a 10% processing fee added up front. We also accept Care Credit and Lending Club.

_____A pre-determination of benefits will only be sent to the insurance at your request.

_____A non-refundable deposit will be required when scheduling IV sedation cases and any surgical appointments at the doctors request.

_____Patients are responsible for the treatment cost not covered by insurance, along with any incurred collection and/or attorney fees. In the event that your account is assigned to a collection agency, you agree to pay a collection fee in the amount of 50% the charged off balance due.

_____ _____

Patient or Guardian **Date**

Cancellation Policy

Colorado Gum Care strives to deliver excellent dental care to all of our patients. In order to be consistent with this philosophy, we have implemented the following appointment cancellation policy:

Surgical Visits

We request that you give our office a seven day notice in the event that you need to reschedule or cancel your procedure with the dentist. This includes all treatment visits with the dentist. If you miss an appointment for the surgical visit without providing us with the proper notice, we will consider this to be a missed appointment and a $150.00 fee may be assessed to reschedule your appointment. This fee will not be applied to your rescheduled procedure.

Office visits and Cleanings

We request that you give our office at least two full business days' notice in the event that you need to reschedule or cancel your appointment with the dentist or hygienist. If you miss an appointment for the office visit without providing us with the proper notice, we will consider this to be a missed appointment and a $75.00 fee may be assessed to reschedule your appointment. This fee will not be applied to your rescheduled procedure.

As a courtesy, we do make reminder calls, texts and/or e-mails 10 days prior to your appointment. We will also contact you to confirm your appointment 3 days prior. If you do not receive your messages or we have incorrect information, the cancellation policy will still be in effect.

_____ _____

Patient or Guardian Date