WELCOME

1 ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____) _____

Payment method: ❑ Cash ❑ Check

_____ ____/____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

4 EMERGENCY CONTACT

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

CONTINUE ON BACK

5 DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw ❑ Lost/Broken Filling(s) ❑ Stained teeth ❑ Broken/Chipped tooth
❑ Blisters/Sores in or around the mouth ❑ Teeth grinding ❑ Locking Jaw ❑ Sensitive tooth, teeth or gums
❑ Red, swollen or bleeding gums ❑ Ringing in Ears ❑ Bad breath ❑ Active Decay/Cavity(ies)

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Have you ever been treated for Gum Disease? ❑ Y ❑ N

Previous Dentist: _____ (____) _____
Name Address Phone#

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____ Last Dental Cleaning: ____/____/____

Have you had problems with previous dental treatment? If so, explain: _____

Times a day you brush?____ Times a week you floss?____ Type of tooth brush bristles? ❑ Soft ❑ Medium ❑ Hard

Rate your Smile from (EXCELLENT=10) 1-10: _____ Would you like whiter teeth? ❑Y ❑N Have you had orthodontic treatment? ❑Y ❑N

Things you would change about your smile? _____

6 MEDICAL HISTORY & INFORMATION

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ **Vitamins/Supplements** _____
❑ Other(s), please list: _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Heart Attack/Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Disease/Angina	**Y N** Shingles
Y N Lung Disease	**Y N** Thyroid Problems	**Y N** Congenital Heart Defect	**Y N** Cancer/Tumor(s)/Growth(s)	**Y N** Hepatitis
Y N Liver Problems	**Y N** Seizures/Epilepsy	**Y N** Artificial Heart Valves	**Y N** Chemotherapy/Radiation	**Y N** Glaucoma
Y N Blood Disease	**Y N** Venereal Disease	**Y N** Mitral Valve Prolapse	**Y N** X-ray or Cobalt Treatment	**Y N** Arthritis/Gout
Y N Kidney Problems	**Y N** Cosmetic Surgery	**Y N** G.I. Problems/Ulcers	**Y N** Frequent Thirst/Urination	**Y N** Leukemia
Y N Scarlet Fever	**Y N** Dizziness/Fainting	**Y N** Emphysema/Asthma	**Y N** Bleeding Problems/Anemia	**Y N** Chest Pains
Y N Tuberculosis TB	**Y N** Cold/Fever Blisters	**Y N** Diabetes/Hypoglycemia	**Y N** High/Low Blood Pressure	**Y N** Bruise Easily
Y N HIV+/AIDS/ARC	**Y N** Blood Transfusion	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Allergies
Y N Rheumatic Fever	**Y N** Alcohol/Drug Abuse	**Y N** Back/Neck Problems	**Y N** Severe/Frequent Headaches	**Y N** Nervousness
Y N Sinus Problems	**Y N** Eating Disorder	**Y N** Respiratory Problems	**Y N** Jaw Problems TMJ/TMD	**Y N** Sleep Apnea

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Codeine
❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No Are you taking hormonal replacement? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Y ❑ N How many children have you had? _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ Initials **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Signature _____ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials _____ Date ____/____/____ Comments

Initials _____ Date ____/____/____ Comments

Initials _____ Date ____/____/____ Comments

Robert M. DiGiorgio, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Robert M. DiGiorgio, D.D.S., P.C.
Master of the Academy of General Dentistry

11027 S. Pikes Peak Drive #105
Parker, Colorado 80138
303-699-6100 (Office)
303-617-1363 (Fax)

FINANCIAL POLICY

Thank you for choosing us as your Dental Healthcare Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial Policy, which we require you to read and sign prior to any treatment.

PATIENTS PORTIONS/DEDUCTIBLE IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, CREDIT CARDS AND CARE CREDIT.

REGARDING INSURANCE

We may accept assignment of insurance benefits. We do require that you pay your portion and/or deductible at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us all your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.

BILLING

You will receive a statement if you have a balance about mid-month. If you didn't pay your portion completely at time of service you will receive a statement. Feel free to call with any questions related to billing.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Insurance adjustments based on in network contractual fees are posted upon payment of claim.

ADULT PATIENTS

Adult patients are responsible for patient portion and deductible at time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for patient portion and deductible. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, major credit card, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS

Appointments cancelled less than 24 hours in advance will incur a charge of $50/per half hour. Please keep in mind that when you cancel with no notice, our staff is here waiting for you and being compensated – please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our financial policy. I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____Signature _____Today's Date

COVID-19 PANDEMIC - PATIENT DISCLOSURES

DOWNTOWN PARKER DENTAL – DR. ROBERT DIGIORGIO

This patient disclosure form seeks information from you that we must consider before making treatment decisions during the COVID-19 virus outbreak

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you recently lost or had a reduction in your sense taste or smell?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside the United States by air or cruise ship in the past 14 days?		
Have you traveled within the United States by air, bus or train within the past 14 days?		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____

Witness

Dental Treatment Consent and Affirmation Form
COVID-19 Reopening

1. I knowingly and willingly consent to dental treatment at Downtown Parker Dental by Dr. Robert DiGiorgio and any designated associates and employees during the reopening phase of COVID-19.

2. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has COVID-19 and who does not given the current limitations and availability in COVID-19 viral testing.

3. Risk of transmission: I understand that due to the frequency of visits of other care dental patients, characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though standard precautions are being observed.

4. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
   A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celsius or higher
   B. Shortness of breath
   C. Dry cough
   D. Runny nose
   E. Sore throat.
   F. Diminished sense of taste or smell

5. Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in paragraph 4 (#4) in the last 14 days.

6. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.

Patient's name (please print)	Signature of patient, legal guardian or authorized representative	Date

Witness to signature	Date