

PATIENT INFORMATION

DATE: _____

NAME: _____ MARRIED SINGLE MALE FEMALE MINOR

ADDRESS: _____
LAST FIRST MI STREET APT # CITY STATE ZIP

BIRTHDATE/AGE _____ / _____ TELEPHONE: () _____ () _____
MO DAY YR AGE HOME OFFICE
 EMAIL: _____
CELL

PLACE OF EMPLOYMENT (or SCHOOL): _____ GRADE: _____ S.S.# _____

DENTAL INSURANCE CO.: _____ GROUP NO. _____
 Has any member of your family ever been treated in our office? YES NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

SPOUSE INFORMATION				
LAST	FIRST	M		
STREET	CITY	STATE	ZIP	
HOME #	WORK#			
MO	DAY	YR	SS#	
EMPLOYER				
DENTAL INSURANCE		GROUP#		
ADDRESS				

RESPONSIBLE PARTY				
LAST	FIRST	M		
STREET	CITY	STATE	ZIP	
HOME #	WORK#			
MO	DAY	YR	SS#	
EMPLOYER				
DENTAL INSURANCE		GROUP#		
ADDRESS				

PERSON RESPONSIBLE FOR ACCOUNT

Check one: Patient Father (or Husband) Mother (or wife) Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY/HOUSEHOLD IN CASE OF EMERGENCY

NAME _____ TEL# _____
Last First MI

ADDRESS _____ TEL# _____
Street City State Zip

METHOD OF PAYMENT

- Payment in full at each appointment. Cash Check Visa/MC
- Phase treatment to fit your budget. Payment plan with approved credit.

In the event I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable **COLLECTION FEE** which shall be 30% of the principal balance for any debt incurred hereunder and to pay all reasonable **ATTORNEY FEES** as a result of my default. **A FINANCE CHARGE OF 1.5% PER MONTH OR 18% PER YEAR WILL BE ADDED TO PAST DUE BALANCES OVER 60 DAYS.**

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I am aware the expected insurance portion is an estimate only given in good faith to the best of our knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge. **THERE WILL BE A \$50.00 CHARGE FOR EACH BROKEN APPOINTMENT IF 24-HOUR NOTICE IS NOT GIVEN.**

If children are under 18, a parent needs to be present for appointment.

STATE DRIVER'S LICENSE NUMBER _____

Signature: **X** _____ DATE: _____

- Adult Patient Father Mother Guardian Foster Parent

SIGNATURE OF RESPONSIBLE PARTY, PARENT IF PATIENT IS A MINOR LEGAL GUARDIAN, FOSTER PARENT

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes

If yes, what is it usually: S /D

Are you allergic or have you had a reaction to:

- | | | | |
|----|--|----|-----|
| a. | Local anesthetics | No | Yes |
| b. | Penicillin or other antibiotics | No | Yes |
| c. | Aspirin | No | Yes |
| d. | Codeine, valium or other sedatives | No | Yes |
| e. | Other _____ | | |

Are you a smoker? No Yes

If so, how much do you smoke per day? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Please list any medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Antacids? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines? No Yes If yes, which ones? _____

Weight: _____

Diet: Restricted Diet _____

How many meals a day _____

Food Allergies _____

Sugar in your diet: None Slight Moderate High

DENTAL HISTORY :

- Do you have a specific dental problem? Describe _____ YES NO
- Do you have dental examinations on a routine basis? Last visit _____ YES NO
- Would you describe your present dental health as good? Comments _____ YES NO
- Do you think you have active decay or gum disease? _____ YES NO
- Do you brush and floss on a routine basis? Discuss _____ YES NO
- Do you feel nervous about having dental treatment? _____ YES NO
- Have you ever had a bad experience in a dental office? Describe _____ YES NO
- Do you want to keep your remaining teeth? _____ YES NO
- Name of previous dentist (optional) _____
- Do you ever brux or grind your teeth? Discuss _____ YES NO
- Have you ever had orthodontic treatment (tooth straightening)? _____ YES NO
- Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss _____ YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)

Patient Signature

Date

Doctor (Print Name)

Doctor Signature

Date

Artistic Smiles Financial Policy

We find that communication with our patients regarding our financial policy assists us in providing the best of service to you. If you have dental insurance, we will offer our assistance in helping you to receive your maximum benefits. In order to do that we need your help and understanding.

As dental providers, our relationship is with you, not your insurance company. All charges are your responsibility. You will be required to pay your estimated co-payments at the time of service. We will bill your primary insurance company for you.

Charges that are not paid by the insurance at thirty days will be your responsibility. Please contact your insurance immediately regarding why they have not paid. This unpaid balance will be your portion at the end of the next billing cycle. We will still assist you in billing your insurance and have them reimburse you for the services. We do accept Visa, MasterCard and Discover. Accounts unpaid ninety days past the date of service are considered delinquent and are subject to collection proceedings. All checks returned for insufficient funds will have a \$25 additional fee added to your account. If you have any questions regarding this financial policy, please contact us at 303-485-8888.

Thank you.

I have read and understand the above

Date: _____ Signature: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

PRINT PATIENT NAME _____ AGE ____ D.O.B. _____

SIGNATURE _____ DATE _____

RELATION TO PATIENT, IF OTHER THAN SELF _____

ARTISTIC SMILES
CLIFF E. ROGGE, D.D.S.
920 S. Hover Rd.
Longmount, CO 80501
(303) 485-8888

It's About Expectations...

As a patient of our practice, you can expect us to:

- Greet you in a friendly, professional manner.
- Seat you as soon after your arrival as possible.
- Do everything possible to make you feel welcome and comfortable.
- Treat you with the utmost professionalism and personal attention.
- Outline the costs associated with any treatment before beginning it.
- Perform painless dentistry
- Provide the most advanced dental procedures and materials.
- Explain the treatment being performed.
- Maintain a clean office.
- Sterilize all dental instruments between patients.
- Assist you in the processing of your insurance claims.
- Make and provide flexible financing arrangements.
- Remind you of your scheduled appointments at least one day in advance.
- Treat any friends or family you refer to us with the same friendly, personal attention.

As a patient of our practice, we expect you to:

- Keep your scheduled appointments.
- Arrive on-time for your appointments.
- Adhere to your financial arrangements.
- Ask questions about anything you do not understand.
- Provide us with current, accurate insurance information.
- Notify us of your general health status including any special needs you may have.
- Brush and floss at least daily.
- See us regularly, i.e., semi-annually, for an exam and cleaning.
- Refer friends and family members to our office.

Signed _____

Patient

Date _____

Signed _____

Dr's Office

Date _____

Smile Analysis

Smiling is the universal body language that tells others how we feel. Smiling is a physical action that affects us emotionally. If we have a beautiful smile we feel happy and confident and if we do not we feel self-conscious. To help you analyze your smile we have developed an objective smile analysis. Our smile evaluation is based on each individual's perception of his or her smile. The questions below are designed to help you reveal your feelings about how your smile makes you feel. To achieve a proper analysis stand in front of a mirror and smile with a normal smile, then think of a funny moment in your life that makes you do a full laughing smile. If you aren't happy with your smile lets figure out what's holding you back.

When I see a picture of myself, the first thing I notice about my smile is _____

Do you ever turn your face or hold your hand in front of your mouth when you smile?
Why? _____

Something I notice about other smiles that I find attractive is _____

Mark the statements you agree with "Y" for Yes "N" for No

_____ I wish the color of my teeth were whiter.

_____ I wish I had a broader smile.

_____ I am missing teeth.

_____ I think some of my teeth are too small.

_____ I think some of my teeth are too large.

_____ I have some teeth that are crooked, uneven, or out of line.

_____ I think my gums show too much when I smile.

_____ I think my smile shows too much space between some of my teeth.

_____ I sometimes hesitate to smile because I am not happy with my teeth.

_____ I have often wished I could change some of the features of my smile.

_____ I feel I don't really know all of the options available for enhancing my smile.

_____ I feel I could do a better job protecting the health of my teeth and gums, therefore, increasing the longevity of my own smile.