Patient Information Forms

Patient Information

Date: _________

Patient Name:____ Male Female

Last First MI (Preferred Name)

☐Married ☐Single ☐Child ☐Other_________ Birth Date: ________________________ Social Security #:____________________

Phone (Cell): ___________Address: ____

Street City State Zip Code

Phone (Other):___________ Email address:______________________________________

Employer: __________________ Occupation: _________________ Phone (Work): _________ Ext.: __

Health Information

Date of Last Dental Visit:_________________________ Reason for today's visit: ____

Have you ever had any of the following? Please check those that apply:

DRUG ALLERGIES

☐ Codeine Allergy
☐ Penicillin Allergy
☐ Latex Allergy
☐ Other_________

MEDICAL HISTORY

☐ AIDS/HIV
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Excessive Bleeding
☐ Glaucoma
☐ Heart Murmur / MVP
☐ Osteoporosis
☐ Osteopenia
☐ Bisphophonate Therapy
☐ High Blood Pressure
☐ Kidney Disease
☐ Mental Health Issues
☐ Pacemaker
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Heart valve replacement
☐ Hepatitis A,B,C

DENTAL HISTORY

☐ Bleeding Gums
☐ Bleaching Treatment
☐ Blisters/ Sores on Lips
☐ Burning sensation on tongue
☐ Cigarette, pipe, or
☐ Gums swollen or
☐ Clench/ Grind Teeth
☐ Bite guard Therapy
☐ Bad Breath
☐ Mouth Breathing
☐ Loose teeth or broken fillings
☐ Jaw Pain or tiredness
☐ Orthodontic treatment
☐ Sensitivity to cold or heat
☐ Marijuana Smoking

Women

Are you pregnant?

Due Date:____________

☐ Are you nursing?

Sterling DENTAL

(970) 522-8518
Fax: (970) 522-8519
cmdb@gmail.com
629 Holly Dr
Sterling, CO 80751

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ______________________________

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: ______________________________

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: ______________________________

• Name of Physician: ____________________ Phone: ____________________
Prescribed Medications: __________ __________ __________
__________ __________ __________
__________ __________ __________

To the best of my knowledge, all of the preceding answers and information provided is true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date: ____________

Signature of patient, parent, or guardian

Responsible Party Information
(If different from Patient)

Name: ____________________ Social Security #: ____________ Birth Date:__________

Phone (Home):__________ Address: ______________________________
Street City State Zip

Employer Name:__________Emp Address: ____________Work Phone:__________

Insurance Information

IF YOU HAVE AN INSURSANCE CARD, GIVE YOUR CARD TO THE RECEPTIONIST. YOU DO NOT NEED TO FILL THIS OUT.

Primary

Name of Insured ____________________ Social Security # ___________ Birth Date __________

Insurance Plan Name:____________________ Group # ___________

S**econdary**

Name of Insured ____________________ Social Security # ___________ Birth Date __________

Insurance Plan Name: ____________________ Group # ___________

Referral Information

Whom may we thank for referring you to our practice? ☐ Dental Office ☐ Internet ☐ Current Patient ☐ Other

Name of person or office referring you to our practice:____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_______________________________________ Date: _________ Relationship to Patient: _____________________________
Signature of patient, parent or guardian

_______________________________________ Date: _________ Relationship to Patient: _____________________________
Signature of guarantor of payment/responsible party

Sterling Dental
629 Holly Drive
Sterling, CO 80014

Acknowledgement of Receipt of Notice of Privacy Practices

* You may refuse to sign this acknowledgement *

Patient information:

Name: ______________________

I, ________________________, acknowledge I have received a Notice of Privacy Practices from Ben Bassett, D.D.S.
print name

Signature: _______________________ Date: _______________
patient

Signature: ________________________________ Date: __________________
parent, or guardian

Relationship:_________________________

Witness:________________________________

Name: Jennifer Simons, Other Date:__________