THE DENVER DENTISTS
& IMPLANT CENTER

Patient Registration

Welcome to our Practice

Chart #: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ **SS#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Employer Name: _____ **Phone:** _____

Occupation: _____

How did you hear about our office?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____ (Emergency Contact Name) _____ (Emergency Contact Phone)

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birthdate: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____ **Phone:** _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birthdate: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____ **Phone:** _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

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Medical History

Patient Name: _____ _____ **Birth Date:** _____
Last First

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bisphosphonates
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ History of osteoporosis and was prescribed any Bisphosphonates like Fosamax or Boniva
- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Subject to frequent headaches
- ☐ A smoker or smoked previously
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician and their specialty:

_____

Most recent physical exam and purpose:

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

List all medications, supplements, and/or vitamins taken currently and for what condition:

Name	Purpose	Name	Purpose

☐ **By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

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Dental Information

Patient Name: _____ _____ **Birth Date:** _____
Last First

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who was your last Dentist and for how long? _____

Reason for leaving your last Dentist: _____

Date of most recent dental exam: _____ **Date of most recent dental x-rays:** _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What are your dental concerns?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most): _____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience ☐ Had complications from past dental treatment ☐ Had trouble getting numb
☐ Had any reactions to local anesthetic ☐ Had/have braces, orthodontic treatment ☐ Had your bite adjusted
☐ Had any teeth removed

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change? _____
☐ Have you ever whitened (bleached) your teeth or are you interested?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?
☐ Are you interested in replacing old silver/amalgam fillings? ☐ Interested in Invisalign, braces or straightening options?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint ☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
☐ You have any problems chewing ☐ You clench you teeth in the daytime or make them sore
☐ You wear or have worn a bite appliance ☐ Your teeth crowding or developing spaces
☐ You have problems with sleep or wake up with soreness in your teeth, shortness of breath or tired
☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits

Tooth Structure, Check all that apply:

☐ Cavities within past 3 years ☐ Food gets caught between any teeth
☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
☐ You notice or have holes (i.e. pitting, craters) on the biting surface of your teeth
☐ Any teeth sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth
☐ Any teeth with grooves, notches, chips, a cracked filling or pain

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing or flossing ☐ Noticed an unpleasant taste or odor in your mouth
☐ Treated for gum disease or were told you have lost bone around your teeth ☐ History of periodontal disease in your family
☐ Experienced gum recession ☐ Experienced a burning sensation in your mouth
☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple

If any of the checked boxes need further explanation, please describe:

_____

_____

Have you had any bad past dental experiences?

_____

_____

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Consent for Services and Financial Policy

Patient Name: _____ _____ **Birth Date:** _____
Last First

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. A service charge of 1 ½% 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.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 lawsuit proceeds.

I understand any appointment cancellations or changes must be communicated on a business day at least 48 hours prior to my scheduled appointment or my account will be charged $50.00 per hour scheduled.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

Consent for Internet Communications and Telecommunications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

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Update HIPAA and Release of Information

Patient Name: _____ _____ **Birth Date:** _____
Last First

☐ **I hereby acknowledge that I have reviewed the Denver Dentists Notice of Privacy Practices.**
(This document can be found on the New Patients area of our website.)

☐ **I authorize the release of information including but not limited to diagnosis, treatment, and financial matters. This information may be released to or discussed with the following person(s):**

Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

☐ **I DO NOT authorize information to be released to anyone.**
This Release of Information will remain in effect until terminated by me in writing.

The Denver Dentists & Implant Center offers E-mail and Text Message notifications for Appointment Reminders and other patient care related information. This system will allow you to verify appointment at a time convenient to you, to request future appointments, and to keep you informed of office and patient care information. If you choose to opt-in to this system please provide us with your email address and text messaging number below. This information is only used for The Denver Dentists & Implant Center purposes and is governed by the same HIPAA protection as all other information.

I authorize The Denver Dentists & Implant Center to notify me of patient care related information using these different methods.

Please check any that apply: ☐ Text Messaging ☐ E-Mail ☐ Voicemail

E-Mail: _____ **Cell Number:** _____

Signature: _____ **Date:** _____

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Photography Release

Patient Name: _____ _____ **Birth Date:** _____

Last First

☐ **I authorize Dr. Burson or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.**

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational and/or marketing purposes in study club meetings, lectures, seminars, demonstrations, social media, and professional publications (such as journals, magazines, Instagram, website and Facebook).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: _____ **Date:** _____