



Aspen Springs Dental
7940 South University Blvd, Suite 200
Centennial, CO 80122
T. (720) 482-0793

Welcome to our office, and thank you for selecting us to help with your dental care. We look forward to meeting you at your upcoming appointment.

Please download and print all of the new patient forms. Please complete them at your convenience and bring them to your appointment. If your employer provides dental insurance, please bring your card with you as well as a list of any prescriptions that you take regularly. If time allows please fax back the forms to our office, this will allow us to verify your insurance benefits.

On your first visit with us we will listen carefully to your dental concerns and attempt to answer all of your questions thoroughly. Our intent is to get to know you and your dental health needs. At your appointment you can expect:

- A thorough examination and review of your oral health
- A careful evaluation of your dental status
- Take any necessary x-rays
- A complimentary video tour/exam of your mouth
- Treatment plan of needed restorations if any
- Cleaning of your teeth

You will find our doctors and their staff to be very friendly, understanding and gentle. We provide our patients exceptional dental treatment in a comfortable and safe environment.

Please arrive 15 minutes early for your first visit so we can review your information with you.

We look forward to seeing you and your family very soon.

Aspen Springs Dental

Name: _____ Gender: F M
Birth date: _____ Soc. Sec. #: _____
Address: _____
Home Phone#: _____ Cell Phone #: _____
Employer: _____ Work Phone #: _____
Email Address: _____
Whom May We Thank For Referring You? _____

Person Responsible For Account (if different from patient)

Name: _____ Gender: F M
Birth date: _____ Soc. Sec. #: _____
Address: _____
Home Phone#: _____ Cell Phone #: _____
Relationship to patient: _____

Dental Insurance Information

Primary

Ins. Co: _____ Employer: _____
Subscriber ID#: _____ Group #: _____
Policy Holder: _____ Gender: F M
Birth date: _____ Soc Sec #: _____

Secondary

Ins. Co: _____ Employer: _____
Subscriber ID#: _____ Group #: _____
Policy Holder: _____ Gender: F M
Birth date: _____ Soc Sec #: _____

Assignment & Release

I agree to assign directly to Aspen Springs Dental all insurance benefits, if any, payable to me for service rendered. I understand that I am financially responsible for all charges not covered by my insurance carrier.

Patient or Guardian Signature

Date

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

- **Payment is due at time of service**
- **We accept Cash, Checks, MasterCard, Visa, Discover**
- **Care Credit Financial payment plans are available
(6, & 12 Mo Interest free options, or extended terms with interest)**

ADULT PATIENTS AND MINORS ACCOMPANIED BY ADULT

Adult patients and adults accompanying a minor patient are responsible for payment at the time of service. Special financial arrangements can be made with the business office before treatment begins.

UNACCOMPANIED MINORS

Proposed treatment sometimes changes during the procedure due to the needs of the tooth. To assure quality care of the patient, it may be necessary to proceed without the consent of the parent or the guardian if they have left the facility. The parent or guardian is responsible for payment the day of treatment, and will be financially responsible for the necessary changes in minor's treatment.

INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND YOUR INSURANCE COMPANY.

As a courtesy to our patients we will file your insurance claims and accept payment from your insurance company. We will be glad to assist you as much as we can with your insurance and to help you to receive the most benefits possible. ***We do request payment of any treatment or percentage of treatment estimated to not be covered by insurance at the time of service.***

We can submit to most insurance companies, as long as your plan allows you to come to the dentists in this practice. If you do not have your current insurance information or if insurance verification is not possible, full payment at time of service is requested. When insurance information is received and entered after your appointment, we will complete the claim forms so that the insurance company will promptly reimburse you.

We will submit claims for you and will accept 3rd party payment from insurance company. We will assist you in receiving the maximum insurance benefits available for your procedure. If your insurance company has not paid their portion within 45 days, the full balance will be your responsibility. You will have an additional 15 days to pay the balance.

RESCHEDULED OR MISSED APPOINTMENTS

We request the courtesy of 48 hours notice should you need to reschedule or cancel your appointment. Missed appointments without 48 hours notice are billed at \$50.00 per hour of appointed time. Please help us serve you better by keeping scheduled appointments.

LATE ACCOUNTS

Balances due for 60 days will be considered delinquent. We reserve the right to forward accounts which are delinquent to an independent service for collection.

Signature _____ Date _____

PATIENT

► Your Name (Patient's Name): _____ Date of last visit: _____

MEDICAL HISTORY

► Physician's Name: _____ Date of last visit: _____

► Have you ever been diagnosed with or experienced the following conditions?

AIDS/HIV	<input type="checkbox"/> Y	<input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Shortness of breath	<input type="checkbox"/> Y	<input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	Sinus trouble	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arthritis, Rheumatism	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N	Skin rash	<input type="checkbox"/> Y	<input type="checkbox"/> N
Artificial heart valves	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Special diet	<input type="checkbox"/> Y	<input type="checkbox"/> N
Artificial joints	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis Type _____	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Swollen feet or ankles	<input type="checkbox"/> Y	<input type="checkbox"/> N
Back problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Swollen neck glands	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bleeds abnormally	<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Blood disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaw pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bone Density Medication	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	Liver disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tumor or growth on head or neck	<input type="checkbox"/> Y	<input type="checkbox"/> N
Chemotherapy	<input type="checkbox"/> Y	<input type="checkbox"/> N	Low blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ulcer	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mitral valve prolapse	<input type="checkbox"/> Y	<input type="checkbox"/> N	Venereal disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Circulatory problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Nervous problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Weight loss, unexplained	<input type="checkbox"/> Y	<input type="checkbox"/> N
Congenital heart lesions	<input type="checkbox"/> Y	<input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y	<input type="checkbox"/> N	Major surgery? _____	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cortisone treatments	<input type="checkbox"/> Y	<input type="checkbox"/> N	Psychiatric care	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hospitalized for? _____	<input type="checkbox"/> Y	<input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Radiation treatment	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you wear contact lenses?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Emphysema	<input type="checkbox"/> Y	<input type="checkbox"/> N	Respiratory disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Take any non-prescribed drugs?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Epilepsy	<input type="checkbox"/> Y	<input type="checkbox"/> N	Scarlet fever	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, what and how often? _____		

► Do you have any other dental or medical condition(s) that could affect your dental treatment? If so, please describe below:

WOMEN ONLY Pregnant? Due date _____ Y N Taking birth control pills? Y N Are you nursing? Y N

► Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). _____ Yes _____ No

► List all medications you are currently taking and the correlating diagnosis:

Med: _____ Dose: _____ Frequency: _____ For: _____

Med: _____ Dose: _____ Frequency: _____ For: _____

Med: _____ Dose: _____ Frequency: _____ For: _____

Med: _____ Dose: _____ Frequency: _____ For: _____

Pharmacy name: _____ Phone (_____) _____

► Indicate all of your allergies below:

Aspirin Iodine Penicillin

Barbiturates Latex Sulfa

Codeine Local Other

anesthetic _____

ACKNOWLEDGEMENT

► **Check ONE** and acknowledge with your signature below:

- I have had no change in my dental or medical history since my last visit.
- I attest that the dental and medical information above is current, complete, true, and accurate. I accept full responsibility for any information not updated or shared with the doctor.

Patient (or Guardian) Signature: _____ **Date:** ____/____/____

Name (if signing for minor): _____

GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, may have some inherent risks.

These risks are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines, which most often lead to clinical success, there are occasional cases, as in any medical treatment, that do not turn out as planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

THANK YOU FOR READING THE GENERAL CONSENT AND OUR FINANCIAL POLICY. LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS:

Patient's signature **Date**

Parent's signature (if minor patient) **Date**

New Patient Questionnaire

Please take a moment to write down what you wish to achieve during your visit today and future visits. We want to know what your main concern is so that we can be sure to address it with you.

We know people sometimes wish their teeth or smile were different. Is there anything you would like to discuss about your smile or teeth?

Do you have any sensitive teeth or areas in your mouth?	Yes	No
Are you happy with your bite?	Yes	No
Is your bite comfortable?	Yes	No
Have you ever had TM (Jaw) joint problems?	Yes	No
Do your jaws click or pop?	Yes	No
Have you had braces in the past?	Yes	No
Do you wear a retainer now?	Yes	No
Have you ever been told you have (periodontal) gum disease?	Yes	No
Do you have any cosmetic bonding on your teeth?	Yes	No
Do you wear a night guard for grinding or clenching?	Yes	No
Does the appearance of the amalgam fillings bother you?	Yes	No
Are you happy with the size and shape of your teeth?	Yes	No
Would you like your teeth to be whiter?	Yes	No

Consent For Use And Disclosure of Health Information

Patient Giving Consent: _____

Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting:

Diane Smith
C/O Practice HIPAA Compliance Officer
7940 South University Blvd, Suite 200
Centennial, CO 80122

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. By signing below you acknowledge you have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. You also consent to our use and disclosure of protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name: _____ Relationship to Patient: _____

REVOCAION OF CONSENT (Do Not Sign This Portion Unless You Are Revoking Your Consent)

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

Thank you for completing your paperwork. We would love to receive your paperwork soon so we can begin transferring your information into your patient file. If you have records you need for us to request and receive before your appointment please complete a Release of Records form and forward to your previous dental office. This can be found in the website forms section, consents and waivers.

If you have insurance and we get your information prior to your appointment we can research how your insurance plan works and be able to answer questions regarding your benefits and any treatment that you may need.

Please return these forms to us by mail, fax or by email, whichever is easier for you.

Our contact numbers are:

- Phone – 303-364-4322
- Fax – 303-577-0190
- Email – aspensprings@rmdentalpartners.com

We look forward to meeting you very soon.

The Doctors and Staff at
Aspen Springs Dental