BOULDER CANYON
DENTAL

Patient Information

First Name *

Last Name *

Middle Initial

Date of Birth *

__/__/____

Age

Social Security Number

Today's date

Gender *

○ Male ○ Female

Marital Status *

○ Single ○ Married ○ Seperated ○ Divorced ○ Widowed ○ Child ○ Other

Are you the patient or are you filling out the forms for them? *

○ I am the Patient
○ I am filling out for the patient

Patient Contact Information

Mobile Phone Number *

(___) ___-____

Email *

Home Phone Number

(___) ___-____

Drivers License

Address 1 *

Address 2

City *

State *

Zip Code *

Emergency Contact Information

Full Name

Phone Number

(___) ___-____

Relationship to Patient

Dental History Information

Name of your previous dentist

Date of last dental visit

__/__/____

Your last cleaning

__/__/____

Your last oral cancer screening

__/__/____

Your last complete X-rays

__/__/____

What is the most important thing to you about your dental visit today?

Why did you leave your previous dentist?

Reason for today's visit

How often do you floss your teeth

Have you ever had an oral cancer screening?

○ Yes ○ No

Do your gums bleed when you brush?

○ Yes ○ No

Have you or a family member ever been treated for periodontal disease?

○ Yes ○ No

Have you ever had complications from an extraction?

○ Yes ○ No

Have you ever had a popping or clicking near your ear when you chew?

○ Yes ○ No

Are you prone to frequent headaches?

○ Yes ○ No

Do you grind or clench your teeth?

○ Yes ○ No

Do you have sores, blisters or swelling on your gums lips or cheeks?

○ Yes ○ No

Have you ever had orthodontic treatment?

○ Yes ○ No

Do you snore?

○ Yes ○ No

Do you have problems with bad breath?

○ Yes ○ No

Have you ever had an allergic reaction to a crown, metal filling or dental appliance?

○ Yes ○ No

Have you ever used an electric toothbrush?

○ Yes ○ No

Are your teeth sensitive to hot, cold or pressure?

○ Yes ○ No

Please mark any of the following conditions that apply to you:

Pain/Discomfort

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Pressure
- ☐ Broken teeth/fillings
- ☐ Worn teeth
- ☐ Dry Mouth

Appearance

- ☐ Discolored teeth
- ☐ Worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Spaces
- ☐ Overbite
- ☐ Flat teeth

Function

- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ) pain
- ☐ Jaw Joint (TMJ) pain/popping
- ☐ Bad Bite
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Sore Muscles (neck, shoulders)
- ☐ Difficulty Opening or Closing
- ☐ Difficulty Chewing on either side

Periodontal (Gum) Health

- ☐ Bleeding, Swollen, Irritated gums
- ☐ Bad breath
- ☐ Loose tipped, shifting teeth
- ☐ Previous perio/gum disease

Habits

- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/Lip biting
- ☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions

- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Bed wetting (for children)

Previous Comfort Options

- ☐ Nitrous Oxide
- ☐ Oral Sedation (Pill)
- ☐ IV Sedation

Tobacco use

○ Yes ○ No

Alcohol use

○ Yes ○ No

Drug use

○ Yes ○ No

Please list family history of any conditions marked:

On a scale of 1-5, with 5 being the highest rating:

How important is your dental health to you? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Where would you rate your current dental health? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Where do you want your dental health to be? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

What would you like to change about your smile?

- ☐ Color
- ☐ Bite
- ☐ Chipped Teeth
- ☐ Spaces
- ☐ Crowding
- ☐ Smile Makeover
- ☐ Missing Teeth
- ☐ Whiter Teeth

What is the most important thing to you about your future smile and dental health?

Dental Insurance Form

Policy Holders Primary Dental Insurance Information

We need your Dental Insurance information NOT your medical insurance information (they are different)

Are you covered under a dental insurance plan? *

○ Yes ○ No

Is the patient the dental insurance policy holder? *

○ Yes ○ No

Policy Holders First Name *

Policy Holders Last Name *

Policy Holders Birth Date *

__/__/____

Policy Holders SSN# *

___-__-____

Policy Holders Employer *

Dental Insurance Carrier *

Dental Insurance phone number *

(___) ___-____

(located on back of your dental insurance card)

ID / Member # *

Group # *

Plan *

Make sure to bring a copy of your insurance card and your driver's license to your appointment so we can scan them into our system. If you have a digital version of your dental card, you can email a copy to frontdesk@bouldercanyondental.com

Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? *

○ Yes ○ No

Have you ever been hospitalized or had a major operation? *

○ Yes ○ No

Have you ever had a serious head or neck injury? *

○ Yes ○ No

Are you taking any medications, pills, or drugs? *

○ Yes ○ No

Do you take, or have you taken, Phen-Fen or Redux? *

○ Yes ○ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? *

○ Yes ○ No

Are you on a special diet? *

○ Yes ○ No

Do you use tobacco? *

○ Yes ○ No

Do you use controlled substances? *

○ Yes ○ No

Women: Are you...

☐ Nursing? ☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Penicillin ☐ Sulfa Drugs

☐ Other?

Do you have, or have you had, any of the following?

AIDS/HIV Positive * ○ Yes ○ No

Alzheimer's Disease * ○ Yes ○ No

Anaphylaxis * ○ Yes ○ No

Anemia * ○ Yes ○ No

Angina * ○ Yes ○ No

Arthritis/Gout * ○ Yes ○ No

Artificial Heart Valve * ○ Yes ○ No

Artificial Joint * ○ Yes ○ No

Asthma * ○ Yes ○ No

Blood Disease * ○ Yes ○ No

Blood Transfusion * ○ Yes ○ No

Breathing Problems * ○ Yes ○ No

Bruise Easily * ○ Yes ○ No

Cancer * ○ Yes ○ No

Chemotherapy * ○ Yes ○ No

Chest Pains * ○ Yes ○ No

Cold Sores/Fever Blisters * ○ Yes ○ No

Congenital Heart Disorder * ○ Yes ○ No

Convulsions * ○ Yes ○ No

Cortisone Medicine * ○ Yes ○ No

Diabetes * ○ Yes ○ No

Drug Addiction * ○ Yes ○ No

Easily Winded * ○ Yes ○ No

Emphysema * ○ Yes ○ No

Epilepsy or Seizures * ○ Yes ○ No

Excessive Bleeding * ○ Yes ○ No

Excessive Thirst * ○ Yes ○ No

Fainting Spells/Dizziness * ○ Yes ○ No

Frequent Cough * ○ Yes ○ No

Frequent Diarrhea * ○ Yes ○ No

Frequent Headaches * ○ Yes ○ No

Genital Herpes * ○ Yes ○ No

Glaucoma * ○ Yes ○ No

Hay Fever * ○ Yes ○ No

Heart Attack/Failure * ○ Yes ○ No

Heart Murmur * ○ Yes ○ No

Heart Pacemaker * ○ Yes ○ No

Heart Trouble/Disease * ○ Yes ○ No

Hemophilia * ○ Yes ○ No

Hepatitis A * ○ Yes ○ No

Hepatitis B or C * ○ Yes ○ No

Herpes * ○ Yes ○ No

High Blood Pressure * ○ Yes ○ No

High Cholesterol * ○ Yes ○ No

Hives or Rash * ○ Yes ○ No

Hypoglycemia * ○ Yes ○ No

Irregular Heartbeat * ○ Yes ○ No

Kidney Problems * ○ Yes ○ No

Leukemia * ○ Yes ○ No

Liver Disease * ○ Yes ○ No

Low Blood Pressure * ○ Yes ○ No

Lung Disease * ○ Yes ○ No

Mitral Valve Prolapse * ○ Yes ○ No

Osteoporosis * ○ Yes ○ No

Pain in Jaw Joints * ○ Yes ○ No

Parathyroid Disease * ○ Yes ○ No

Psychiatric Care * ○ Yes ○ No

Radiation Treatments * ○ Yes ○ No

Recent Weight Loss * ○ Yes ○ No

Renal Dialysis * ○ Yes ○ No

Rheumatic Fever * ○ Yes ○ No

Rheumatism * ○ Yes ○ No

Scarlet Fever * ○ Yes ○ No

Shingles * ○ Yes ○ No

Sickle Cell Disease * ○ Yes ○ No

Sinus Trouble * ○ Yes ○ No

Spina Bifida * ○ Yes ○ No

Stomach/Intestinal Disease * ○ Yes ○ No

Stroke * ○ Yes ○ No

Swelling of Limbs * ○ Yes ○ No

Thyroid Disease * ○ Yes ○ No

Tonsillitis * ○ Yes ○ No

Tuberculosis * ○ Yes ○ No

Tumors or Growths * ○ Yes ○ No

Ulcers * ○ Yes ○ No

Venereal Disease * ○ Yes ○ No

Yellow Jaundice * ○ Yes ○ No

Have you ever had any serious illness not listed above? * ○ Yes ○ No

Comments:

Initials_____

Financial Policy

We require that all patients sign our Financial Policy Form before receiving dental treatment.

Patient Responsibility

Patients or their legal representative are ultimately responsible for all charges for services received. We expect your payment before or at the time of your visit for all charges owed. When you make a payment, you will pay an estimated patient responsibility and when your insurance has determined their final coverage, we will either send you a statement for the balance due or issue a refund in case of overpayment.

Types of Payments

1. Deductibles- Most insurances have a yearly deductible which varies by carrier. When your insurance completes processing of your dental claim, you may be responsible for the additional amount.
2. Co-Insurance- Some insurance plans require you to pay a certain percentage (for example 50%) of the allowable charge amount. Our office verifies your breakdown as best as we can an estimates the out-of-pocket cost for you based on the information you provide. However, this is always an estimate, any fees not paid by your insurance is the responsibility of you as the patient once claims have been processed. We submit pre-authorizations for treatment only at the request of the patient.
3. Secondary Insurance- We do not submit to secondary insurance. You can submit to your secondary on your own once you receive your EOB from your primary after it has paid.
4. Treatment Plan Fees- The total fee on treatment plan is the agreed upon fee with or without insurance estimation of coverage and will be the amount responsible to the patient if insurance denies coverage for any reason. Although your insurance carrier informs us, they will cover up to a certain amount, they maintain the right to alter coverage at any time and are not required to notify our office of any changes. If your insurance has lapsed or is denied, or the fee schedule has changed then you will be subject to our standard fees.
5. Uninsured/self-pay patients- If you do not have insurance, payment of all services is due prior or day of treatment.
6. Non-covered services-It is your responsibility to contact your insurance plan to determine services covered. If we provide you with a non-covered service, you will be responsible for all fees related to this non-covered service
7. Updating Dental Insurance information- It is also your responsibility to contact our office with insurance plan changes at least 72 hours before your dental visit. Failure to provide this before we can validate will result in collecting at standard fees that can be refunded after your claim is processed.
8. Claim Denials due to wrong information- If we are not provided with the correct insurance information, we will re-submit your claim 1 additional time as a courtesy. If there are issues with processing the claim after that resubmittal, then submitting the claim will be the responsibility of the patient and all fees associated with the appointment will be the responsibility of the patient at our standard fees.
9. Deposits- Scheduling deposits are required for certain procedures and the terms of the deposit/rescheduling fees will be printed on the signed treatment plan.
10. New Patient Special- The new patient special is a courtesy fee of $99 for a patient to establish care at this practice. This can be used for an emergency appointment for exam and necessary x rays or for a new patient hygiene appointment which includes x rays, exam and healthy patient prophylaxis or initial debridement.
11. Records Release Fee- There is no fee for requesting JPEG images of x-rays emailed directly to the patient.
12. Follow up visits- If we need to see you for a follow up to a recent procedure, there will not be a fee for this follow up visit, however if over 30 days has past since any treatment has been performed then there still be a fee for the appointment that may or may not be covered by your insurance company.

New Patient Expectations

Our office requires a FULL set of diagnostic x rays in order to establish care. Dental insurances have frequency limitations on comprehensive exams/limited exams, x-rays, cleanings as well as other services. If your insurance carrier determines that your frequence has been met, you will have an out-of-pocket cost. If you would like to know your frequence status prior to your visit, please contact your insurance.

No-Show Policy

Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "no-show" Appointment

Boulder Canyon Dental defines a "no-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment.
- Cancels or reschedules with less than 72 hours' notice (surgery and other procedures may have their own policy outlines on the signed treatment plan).

Impact of a "no-show" appointment

"no-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows_ a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient.
- Negatively impacts access for other patients that could have been seen in the appointment slot.
- Disrespects not only the provider's time, but also the time of the entire clinical staff.

Consequences of "no-show" appointments

If you "no-show" 3 or more appointments within 18months you may be dismissed from Boulder Canyon Dental.

1. Frist offense, no fee will be applied if due to an emergency or being sick.
2. Second offense, the patient will be charged $75.
3. Third offense, the patient will be charged $75 and will be dismissed from the practice.
4. If you are dismissed from the practice, you may request your records to be released per our records release policy.
5. Re-admittance requests can be submitted to the clinic 12months after the initial dismissal and but does not guarantee that the patient will be allowed back to the office.

How to Avoid getting a "no-show"

1. Arrive 15 minutes early- When you schedule an office visit with us, we expect you to arrive out our practice 15minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and/or to complete any necessary paperwork.
2. Give 72-hour notice to cancel or reschedule your appointment. When you need to reschedule or cancel, we expect you to contact our office via phone or text message. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patients. If it is less than 72 hours before your appointment, please call us directly.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 healthcare 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 healthcare 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.

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.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Authorization To Release Information

Would you like to authorize the office to release information regarding yourself covered under the Privacy Act to individuals other than yourself? *

○ Yes ○ No

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

I hereby authorize the above person(s) to have access to information covered under the Privacy Practice regarding myself.

Patient's First Name *

Patient's Last Name *

☐ I am signing on behalf of the patient

Signature *

Today's Date

How did you hear about us?

Please select at least 1 option
*

- [ ] In-home Mailer
- [ ] Social Media
- [ ] Insurance
- [ ] Practice Website
- [ ] Internet
- [ ] Family / Friend / Co-worker
- [ ] Other

To the best of my knowledge, all the information I have provided is true.

Patients First Name *

Patients Last Name *

Signature *

Today's Date