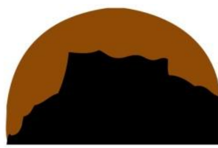

Patient Information

Name: Last	First	Middle	I Prefer to be called:	Sex: ( ) Male ( ) Female
Address: Street/PO Box	City	State	Zip	Phone Numbers Work: Home: Cell:
E-mail Address	Date of Birth	Social Security No.(If Child, Parent's SS#)		
Occupation	Employer	How long employed?	Address & Phone No.	
Person responsible for bill	Social Security No.	Relationship	Address & Phone No.	
Occupation	Employer	How long employed?	Address & Phone No.	

Insurance Information

Insured person's full name			
Social Security No.	Relationship to patient	Work phone	Cell phone
Insurance company name	Group name	Group number	
Employers name	Full Address of Employer		

Are you covered under more than one dental plan? ❑ No ❑ Yes

Payment Alternatives – (Please check appropriate box)

❑1. If you do not have insurance, we offer a cash courtesy if you pay your entire treatment plan in full, at the time of service.

❑2. Cash and personal checks are accepted as your treatments are provided.

❑3. For long term or extended payments, we offer a health care financing program, which when you are accepted, will allow extended small monthly payments for the treatment received

❑4. MasterCard, Visa, or Discover

❑5. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist in verifying the coverage that your particular program provides. We accept assignment of your insurance payments, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason does not honor their commitment to you and to us.

FOR ALL PATIENTS:

I herby authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems clinically necessary. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I understand that I will be charged a fee of $50.00 per hour for any scheduled appointment that I fail to cancel 24 hours prior. In conjunction with my insurance company I agree to pay for all services rendered by this office.

Signature of responsible party____ Relationship____________________ Date____________

ASSIGNMENT & RELEASE:

I the undersigned certify that I (or my dependent) have insurance coverage with ___________________and assign directly to **Shadow Rock Dentist** all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.

Signature of responsible party____ Relationship____________________ Date____________

Getting to Know You

Patient Name: ____ ___________ Date: ________________

Whom may we thank for referring you? ____

Is another member of you immediate family or a relative a patient in our practice? _________________________

Person to contact in case of emergency ? ______________________________ Phone #: ____________________

Reason for today's visit? ____

____

2014 Health History

Please complete the following confidential form. The information provided is important to your dental health.

Do you have or have you had any of the following?
(Please check any that apply)

❑ AIDS/HIV Positive	❑ Cortisone Medicine	❑ Liver Disease
❑ Alcoholism	❑ Diabetes	❑ Low Blood Pressure
❑ Allergies or Hives	❑ Drug Addiction	❑ Metal Allergy
❑ Alzheimer's Disease	❑ Emphysema	❑ Mitral Valve Prolapse
❑ Angina (Chest Pain)	❑ Epilepsy, seizures, or fainting spells	❑ Pain in Jaw
❑ Anemia	❑ Genital Herpes	❑ Psychiatric Treatment
❑ Arthritis	❑ Glaucoma	❑ Radiation Treatments
❑ Artificial Joint or Heart Valve	❑ Hayfever or sinus trouble	❑ Rheumatic fever
❑ Asthma	❑ Heart Attack or Heart Disease	❑ Rheumatism
❑ Osteoporosis Medication	❑ Heart Pace Maker	❑ Sickle Cell Disease
❑ Blood Transfusion	❑ Hemophilia	❑ Sleeping Disorder
❑ Bruise Easily	❑ Hepatitis A, B, or C	❑ Stroke
❑ Cancer	❑ High Cholesterol	❑ Thyroid Disease
❑ Chemotherapy	❑ High Blood Pressure	❑ Tuberculosis (TB)
❑ Cold Sores/Herpes/Fever Blisters	❑ Kidney Problems	❑ Ulcers
❑ Congenital Heart Disorder		❑ Venereal Disease

List all medications you are taking at this time (dosage and necessity):____

____

Do you have any disease, condition, or problem not listed? ____ If yes, please list: _________

____

Have you had surgery or been under the care of a medical doctor during the past two years?

____

If yes, for what reason: ____

Physician Name: ______________________Telephone Number :________________________

Have you ever been told to premedicate with antibiotics prior to dental care? YES or NO

Have you ever had excessive bleeding requiring special treatment? YES or NO

Do you use, or have you used tobacco products? YES or NO

If yes, what kind of tobacco products?____

Do you use, or have you used recreational drugs? YES or NO

Are you on coumadin or other blood thinners? YES or NO

Are you allergic to or made sick by:
(i.e. itching, rash, swelling)

- ❑ Latex Materials: ___________
- ❑ Metal: __________________
- ❑ Penicillin
- ❑ Local Anesthetics ("Novocain")
- ❑ Codeine or other Narcotics
- ❑ Sulfa Drugs
- ❑ Barbiturates (sleeping pills),
- ❑ Aspirin
- ❑ Nitrous Oxide
- ❑ Erythromycin
- ❑ Clindamycin
- ❑ Other: ____________________

For Women:

- ❑ Are you Pregnant? Delivery Date:________
- ❑ Taking birth control pills?
- ❑ On medication for menopause?

I understand that 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 to release information to you. Patient or Parent/Guardian Signiture:____ Date:_________________

Dental History

Are you having a problem which requires immediate treatment?____

Date of last dental cleaning? ______________________ Date of last full set of x-rays? __________________________

Date of last dental appointment? ___________________ What was done at that time? ______________________

Name of previous dentist? ____ Phone #: _________________________

Address: ____

Reason for leaving previous dentist? ____

Please check a box for each item listed below:

Do you feel nervous about having dental treatment done?..................................... ❑ Yes ❑ No
Have you ever had an upsetting dental visit?.. ❑ Yes ❑ No
Are you interested in or do you think you need nitrous or oral sedation?..............❑ Yes ❑ No
Would you like to keep all of your teeth all of your life?....................................... ❑ Yes ❑ No

Are any of your teeth sensitive to:
Hot or cold……….❑ Yes ❑ No
Sweets……………❑ Yes ❑ No
Biting/Chewing…..❑ Yes ❑ No

Do you use:
Dental Floss………. ❑ Yes ❑ No ____times/week
A soft toothbrush…..❑ Yes ❑ No ____times/day
Electric toothbrush...❑ Yes ❑ No ____times/day

Do your gums bleed or hurt?.. ❑ Yes ❑ No explain______________________
Do you have any loose teeth?... ❑ Yes ❑ No explain: ____________________
Does food ever get caught between teeth?.................................. ❑ Yes ❑ No explain: ___________________________
Do you bite your lips or cheek frequently?................................. ❑ Yes ❑ No explain: ___________________________
Do you hold foreign objects with your teeth (pens, pipe, etc.)?.... ❑ Yes ❑ No explain: ___________________________
Do you mouth breath while awake or asleep?..............................❑ Yes ❑ No explain: ___________________________
Do you have popping or clicking in your jaw?............................. ❑ Yes ❑ No explain: ___________________________
Do you experience pain (jaw, joint, ear, or side of face)?............ ❑ Yes ❑ No explain: ___________________________
Do you have difficulty opening or closing your mouth?...............❑ Yes ❑ No explain: ___________________________
Do you have difficulty chewing on either side of your mouth?..... ❑ Yes ❑ No explain: ___________________________
Do you have tired jaws, especially in the morning?...................... ❑ Yes ❑ No explain: ___________________________
Do you get tension headaches?.. ❑ Yes ❑ No explain: _____________________
Do you clench or grind your teeth while awake or asleep?........... ❑ Yes ❑ No explain: ___________________________
Have you had any teeth removed?..❑ Yes ❑ No explain: ___________________________
Have you had orthodontic (braces) treatment?............................. ❑ Yes ❑ No explain: ___________________________
Have you had periodontic treatment?...❑ Yes ❑ No explain: ___________________________
Are you happy with the color of your teeth?................................❑ Yes ❑ No explain: ___________________________

How do you feel about the appearance of your teeth, if you could change anything, what would you change?____

Doctor's Notes: *Dr. Signature:* _____________________________

____
____

Shadow Rock Dentistry
Dr. Vikash (Vik) Kanchanlal
734 Wilcox Street Suite 200
Castle Rock, CO 80104
Phone: 303.257.8237

Federal Health Insurance Portability and Accountability Act (HIPAA) Acknowledgement

This acknowledgement meets the HIPAA requirement to inform you of the various ways in which we may need to use your confidential information.

- Providing dental care services.
- Collecting payment for your dental services.
- Support the operation of this practice.

In order to comply with the new federal law, we have clearly posted a copy of our Notice of Privacy Practices and have made a copy available for you to take home and read at your leisure. We want you to feel free to contact our office if you have any questions after reading the Notice.

If you are not available to answer our calls, may we leave a voice mail message?
☐ Yes ☐ No

Please indicate the phone number(s) you would like us to leave messages on.

Home ______________________________________

Work ______________________________________

Other ______________________________________

______________________________________ ______________________________
Print Name Date

____
Signature