Signature
Dentistry of Arvada

Patient Information (confidential)

Name: ______________________________ Birthday: _________________ Phone #: _____________________
Address: ___________________________________ City: _____________________ State/Zip: ______________
E-mail: ____ Soc. Sec #: __________________________
Check appropriate: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's Employer: ____ Work phone: ___________________
Spouse or Patient/Guardian's Name: __________________________________ Phone #: ___________________
Whom may we thank for referring you? ____
Person to contact in case of emergency: ____________________________ Phone #: ______________________

Responsible Party

Name of person responsible for this account: ___________________________ Relationship: ________________
Address: ____
E-mail: ____ Phone #: _________________________
Driver's License #: ____ Birthday: _________________________
SSN: ____________________ Employer: _____________________________ Work phone: _________________

Insurance Information

Name of Insured: ____ Relationship: ____________________
Birthday: ____ SSN: ____________________________
Name of employer: _______________________________________ Date Employed: _____________________
Insurance Company: _______________________ ID #: ________________________ Grp #: ________________
Ins. Co. Address: ____ Ins. Co. Phone #: _________________
DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THE FOLLOWING:
Name of Insured: ____ Relationship: ____________________
Birthday: ____ SSN: ____________________________
Name of employer: _______________________________________ Date Employed: _____________________
Insurance Company: _______________________ ID #: ________________________ Grp #: ________________
Ins. Co. Address: ____ Ins. Co. Phone #: _________________

Patient's Medical History

Patient's Name: ______________________________________ Birthday: ____________________________

Although dental personnel treat the area in and around your mouth, your mouth is part of your entire body. Health Problems that you may have, or medication that you are taking, could have an important interrelationship with the dentistry you receive.

Are you under a physician's care now? ☐ Yes ☐ No ☐ N/A __________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ☐ N/A __________

If yes, please specify? ____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No ☐ N/A __________

If yes, please specify? ____

Are you taking any medication, pills, or prescription drugs? ☐ Yes ☐ No ☐ N/A __________

If yes, please specify? ____

Have you ever taken Fosamax, Bonvia, Actonel, or any other medications containing bisphosphonates?
☐ Yes ☐ No☐ N/A. _________

Are you on a special diet? ☐ Yes ☐ No ☐ N/A __________

Do you use Tobacco? ☐ Yes ☐ No ☐ N/A __________

Do you use controlled substances ☐ Yes ☐ No ☐ N/A __________

Women: Are you ☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking Oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex
☐ Local Anesthetics __________________ ☐ Other (please specify) ______________________________

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

☐ AIDS/HIV Positive	☐ Chest pains	☐ Frequent Headaches	☐ Irregular Heart beat
☐ Alzheimer's Disease	☐ Cold Sores/ Fever blisters	☐ Genital Herpes	☐ Kidney Problems
☐ Alcoholism	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia
☐ Anaphylaxis	☐ Convulsions	☐ Hay Fever	☐ Liver Disease
☐ Anemia	☐ Cortisone Medicine	☐ Heart Attack/ failure	☐ Low Blood Pressure
☐ Arthritis/ Gout	☐ Diabetes	☐ Heart Murmur *	☐ Lung Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Pain in Jaw Joints

Signature Dentistry of Arvada

☐ Artificial Joint*	☐ Easily winded	☐ Heart Disease	☐ Psychiatric Care
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Radiation Treatment
☐ Bisphosphonates	☐ Epilepsy/ Seizures	☐ Hepatitis A	☐ Recent Weight Loss
☐ Blood Disease	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Blood Transfusion	☐ Excessive Thirst	☐ Herpes	☐ Rheumatism
☐ Breathing Problems	☐ Fainting Spells/ Dizziness	☐ High Blood Pressure	☐ Scarlet Fever
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Shingles
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Stroke

*condition may require medication

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

If yes, please specify: ____

____

____

Do you wish to talk to the doctor privately about a concern? ☐ Yes ☐ NO

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period id such dental care to third party payers and/or health practitioners.

____

Signature of Patient, Parent or Guardian   Date

Dental History

Patient Name: ___________________________________ Birthday: _________________________

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, Sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw Joint pain
- ☐ Grinding or clinching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the Following:

- ☐ Dentures
- ☐ Periodontal (gum) treatments
- ☐ Braces

Please share the following dates:

- ☐ Your Last Cleaning _______________________
- ☐ Your last oral cancer screening __________________
- ☐ Your last complete x-ray set _____________________

Are you interested in whiter teeth? ☐ Yes ☐ No

Do you smoke or use chewing tobacco?

☐ Yes How much? ________

How Long? _________

☐ No

If you could change your smile, would you:

- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Close Spaces
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Have smile makeover

Name of Previous Dentist:

____

Phone Number ___________________________

TREATMENT CONSENT

I authorize Signature Dentistry of Arvada, Dr. Michael W. Woods and staff to perform dental treatment for me. After a thorough examination and diagnosis, I have been informed of the recommended treatment plan, and the benefits and risks involved. I have been informed of the risks of inadequate or non-treatment, and the fee.

I acknowledge that no guarantees have been made to me concerning the results of my dental treatment. As risk of failure, relapse, or worsening of my dental condition may result regardless of the efforts made during treatment. Additional treatment or retreatment is always a possibility. I recognize that long term success depends upon my cooperation and routine maintenance as well.

I specifically authorize my dentist to select alternative methods of treatment based on my condition as disclosed during the procedures, including conditions which were unknown at the time dental treatment was initiated. These additional procedures may include, but are not limited to, endodontic treatment, more extensive restorations, or tooth loss.

I understand that there are substantial risks and consequences that may be associated with any surgical, diagnostic, or anesthetic procedure. I understand that not every conceivable hazard can be listed, but that the following possibilities exist, however infrequent or rare: Excessive bleeding, pain, swelling, infection, allergic reactions to medications and anesthetic, bruising, speech changes, food impaction areas, numbness of the lip, tongue or facial area. Knowing these risks, I consent to treatment.

Patient Signature: ____ Date: ______________

FINANCIAL AND CANCELLATION AGREEMENT

Cancellation Policy

Each patient appointment is given a reserved amount of time in our practice and we do not double-book patients to compensate for cancellations. However, we also understand that life can have unexpected happenings and it may become necessary to change an appointment date.

If it is necessary to cancel and reschedule an appointment, we do REQURE a 24-HOUR NOTIFICATION to avoid a $50.00 cancellation fee.

Payment Policy

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the quality care needed to enjoy a healthy and confident smile.

Payment in Full

Full payment is required at the time of service from all patients that do not have insurance coverage.

Dental Insurance

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. We cannot guarantee any estimated coverage. Your unpaid deductible and any estimated portion of fees not covered by your insurance are due at the time of service. Because the insurance policy is an agreement between you and the insurance company, we ask that patients be directly responsible for all charges. If for any reason your insurance company has not paid their portion within 90 days from the start of treatment, you are responsible for payment at that time.

I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party I am accepting full financial responsibility for payment of all charges provided to me.

I agree that if my employer, insurance carrier or plan sponsor denies payment to all of or any portion of my claim, I will be financially responsible for all outstanding charges.

I hereby, authorize any insurance payment directly to Signature Dentistry of Arvada, Dr. Michael Woods.

Payment Options

- CASH OR CHECK
- CREDIT CARDS: For your convenience, we have made arrangements to accept payment by Discover, Mastercard, and Visa
- PAYMENT PLANS: For patients who desire a monthly payment plan, we have made arrangements with a finance company such as CareCredit and Proceed.

Past Due Balances

A past due balance is any amount owed from a previous visit where insurance is not pending or an insurance payment has not been received within 90 days. All unpaid balances are subject to a potential monthly service charge. Any delinquent account will be required to pay all past due balances in full before incurring any new charges. All future charges will need to be paid at the time services are rendered. Severely delinquent accounts will be assigned to a collection agency.

In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 33% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.

Returned Checks

Checks returned for insufficient funds will be subject to a $30.00 service fee.

Patient Signature: ____ Date: ______________

TCPA ACKNOWLEDGEMENT

I authorize this office, its agents and assignees to contact me by telephone, text, e-mail, SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.

Patient Signature: ____ Date: ______________

Receipt of Privacy Practices – Acknowledgement

YOU MAY REFUSE TO SIGN THIS

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices:

____
Please Print

____

Signature

____
Date

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgement of Receipt of our Notice of Privacy Practices was attempted, however acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other

____

____

Covid-19 Patient Disclosures

This patient disclosure form seeks information from you that we must consider before masking treatment decisions in the circumstance of the COVID-19 virus.

A weak or comprised immune system (Including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	YES	NO
Have you received the COVD-19 Vaccine	☐	☐
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or trouble breathing?	☐	☐
Do you have a dry cough, runny nose, or sore throat?	☐	☐
Have you recently lost or had reduction in your sense of smell/taste?	☐	☐
Have you been in contact with someone who has tested positive for COVID- 19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested and are awaiting results?	☐	☐
Have you traveled outside the United States?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have fully disclosed to my provider any conditions in my health history which may result in a comprised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Adult Sleep & Breathing Questionnaire

Date: ___________________

Patient's Name: ____

Male _______ Female ________ Date of Birth: ________________ Age: _________________

Have you ever had a sleep test administered: YES ☐ NO ☐

If yes, when did you have your last sleep test? ____

Have you been diagnosed with sleep apnea? YES ☐ NO ☐
Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? YES ☐ NO ☐
Are you happy with your CPAP or Sleep Appliance? YES ☐ NO ☐
If you are not happy, why?
____

____

How often do you get out of bed to use the restroom during the night? ____________________

Do you usually wake feeling tired and unrested? YES ☐ NO ☐
Do you habitually snore? YES ☐ NO ☐
Have you been diagnosed with hypertension/ high blood pressure? YES ☐ NO ☐
Do you often suffer from waking headaches? YES ☐ NO ☐
Do you have blocked nasal passages? YES ☐ NO ☐
Has anyone observed you stop breathing during your sleep? YES ☐ NO ☐
Do you ever wake up gasping or choking? YES ☐ NO ☐
Do you grind your teeth while sleeping? YES ☐ NO ☐
Is your neck circumference greater than 40cm/ 15.75"? YES ☐ NO ☐
Is your body mass index (BMI) more than 35? YES ☐ NO ☐

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contract to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0= no chance of dozing
1= slight chance of dozing
2= moderate change of dozing
3= high chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching T. V	
Sitting inactive in a public place (like a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting quietly after lunch without alcohol	
Sitting and talking to someone	
In a car, while stopped for a few minutes in traffic	

TOTAL ______________

Analyze your score:
0-7 It is unlikely that you are abnormally sleepy
8-9 You have an average amount of daytime sleepiness
10-15 You may be excessively sleepy, depending on the situation. You may want to consider seeing medical attention
16-20 You are excessively sleepy and should seek medical attention