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 #: _____

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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

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☐ 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

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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 _____

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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: _____

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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 $65.00 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.

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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: _____

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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: _____

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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

_____

_____

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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 ☐

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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

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