Patient Number ______ A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last ______ First ______ Middle Initial ______ SEX: M F BIRTHDATE ______ AGE ______

Soc. Sec. # ______ If Patient is a Minor, give Parent's or Guardian's Name ______ TODAY'S DATE ______

Who May We Thank for Referring You to our Office? ______ Reason for this Visit ______

RESPONSIBLE PARTY INFORMATION

NAME Last ______ First ______ Middle Initial ______ MARITAL STATUS ______

RESIDENCE Street ______ Apt. # ______ City ______ State ______ Zip ______

MAILING ADDRESS Street ______ Apt. # ______ City ______ State ______ Zip ______

HOW LONG AT THIS ADDRESS ______ HOME PHONE ______ CELL PHONE ______

WORK PHONE ______ E-MAIL ______

PREVIOUS ADDRESS (if less than 3 yrs.) Street ______ City ______ State ______ Zip ______ How Long ______

SOCIAL SECURITY # ______ BIRTHDATE ______ DRIVER'S LICENSE # ______ RELATION TO PATIENT ______

EMPLOYER ______ OCCUPATION ______ NO. YEARS EMPLOYED ______

RESPONSIBLE PARTY'S SPOUSE

NAME ______ (LAST / FIRST / MIDDLE)

EMPLOYER ______ OCCUPATION ______ ( ) NO. YEARS EMPLOYED

SOC. SEC. # ______ BIRTHDATE ______

HOME PH. ______ CELL PH. ______

WORK PH. ______ E-MAIL ______

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME ______ RELATIONSHIP ______

ADDRESS ______ CITY, STATE ______

HOME PH. ______ CELL PH. ______

WORK PH. ______

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______

Insurance Co. ______ E-MAIL ______

Insurance Co. Address ______

Insured's Employer ______

Insured's Soc. Sec. # ______ Group # ______ Local # ______

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name ______

Insurance Co. ______ E-MAIL ______

Insurance Co. Address ______

Insured's Employer ______

Insured's Soc. Sec. # ______ Group # ______ Local # ______

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE:(16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✔ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐				Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies (latex, wool, metal, chemicals)	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐				Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.)
Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances?
If yes, please list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN ______ PHONE ______ E-MAIL ______

PATIENT Signature (Parent of Child) ______ Date: ______ DENTIST Signature ______

6179 SOUTH BALSAM WAY SUITE 220
LITTLETON, COLORADO 80123
PHONE: 303 932-2872
FAX: 303 933-3486

CONSENT FORM

The undersigned hereby authorizes the Doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. The medical information supplied by me on the front side of the "Health History & Registration form is accurate and complete to the best of my knowledge.
I will not hold my doctor or any member of his/hers staff responsible for any errors or omissions that I may have made in the completion of this form.
I also understand the use of anesthetic agents embodies a certain risk.
I understand that my dental insurance is a contract between the insurance carrier, and myself and not between the insurance carrier and the Doctors and that I am still fully responsible for all dental fees. I also assign all insurance benefits to the Doctors, and any payments received to my account or refunded to me if I have paid the dental fees in advance. If financial arrangements are needed and are not made before services are rendered and your account becomes delinquent within 90 days, a charge of 21 percent interest per year will apply and be turned over to a Credit Bureau. In the event an overdue balance occurs, I accept all responsibility of paying attorneys' fees.

Signature ____ Date_______________

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned patient or legally authorized representative "Agent" of the patient acknowledges that he or she personally received a copy or was offered a copy of the Creer Family Dentistry Notice of Privacy Policies on the date indicated below. Patient understands the privacy policy and was given the opportunity to ask any questions.

Signature ____ Date_______________

Printed Name ____

CANCELLATION POLICY

We know your time is valuable and we try to schedule in the best fit possible. Please be courteous and notify our office as soon as you know you will be unable to make a previously scheduled appointment. If it is necessary to cancel your appointment, we **require a 24 hour notice.** This allows us a chance to schedule another patient in your place. Appointments **cancelled in less than 24 hours** or patients who **do not show up** for their scheduled appointment **will incur a $50 cancellation fee.**

Patients with a history of failing appointments or repeated late cancellations may be dismissed from the practice.

Signature ____ Date_______________