FRUITA CANYON DENTAL

288 West Pabor Ave. Fruita, CO | Make an Appointment Today: 970.858.8484

First Name:_____ **Last Name:** _____ **Middle Initial:** _____

Address: _____**City, State, Zip:** _____ **Preferred Name:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Receive Correspondence Via Text: YES: ☐ **NO:** ☐ **Sex: Male:** ☐ **Female:** ☐

Receive Correspondence Via Email: YES: ☐ **NO:** ☐ **Marital Status: Married:** ☐ **Single:** ☐ **Divorced:** ☐ **Widowed:** ☐

Email: _____ **How Were you Referred to Us:** _____

Birth Date: _____**Age:** _____ **Social Security:** _____-_____-_____ **Drivers License:** _____

Physician: _____ **Phone Number:** _____

Emergency Contact: _____**Relation to Patient:** _____ **Phone Number:** _____

I CONSENT TO DENTAL TREATMENT BY FRUITA CANYON DENTAL LLC AND STAFF

Signature: _____ **Date:** _____

Responsible Party: (If other than patient)

First Name: _____**Last Name:** _____**Middle Initial:** _____

Address: _____ **City, State, Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Birth Date: _____ **Social Security:** _____-_____-_____ **Relationship to Patient:** _____

Primary Insurance:

Name of Policy Holder: _____ **Relationship to Patient: Self:** ☐**Spouse:** ☐**Parent:** ☐**Other:** ☐

Policy Holder Social Security: _____-_____-_____ **Member ID#:** _____**Policy Holder Birth Date:** _____

Group #: _____ **Primary Insurance Holders Phone #:** _____ **Address:**_____

Insurance Company:_____

Employer : _____ **Insurance Phone #:** _____

Employer Phone #: _____ **Address:** _____

City, State, Zip: _____

Secondary Insurance: (if applicable)

Name of Policy Holder: _____ **Relationship to Patient: Self:** ☐**Spouse:** ☐**Parent:** ☐**Other:** ☐

Policy Holder Social Security: _____-_____-_____**Member ID#:** _____**Policy Holder Birth Date:** _____

Group #: _____ **Secondary Insurance Holders Phone #:** _____ **Address:**_____

Insurance Company:_____

Employer : _____ **Insurance Phone #:** _____

Employer Phone #: _____ **Address:** _____

City, State, Zip: _____

I AUTHORIZE THE RELEASE OF AN INFORMATION RELATING TO CLAIMS AND WISH TO ASSIGN BENEFITS TO FRUITA CANYON DENTAL

AS PER HIPAA, OUR OFFICE HAS A PRIVACY POLICY IN ORDER TO KEEP YOUR PERSONAL INFORMATION PRIVATE. IF YOU WANT MORE INFORMATION ABOUT OUR PRIVACY PRACTICES, AND/OR A COPY OF OUR HIPAA PRIVACY POLICY, PLEASE ASK THE FRONT OFFICE. TO MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT.

Signature: _____**Date:** _____

Time 12:04 PM | Fruita Canyon Dental | Date 5/16/2018

Medical History

Patient Name: | Birth Date: | Date Created:

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, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a joint replacement?	Yes No	If yes
Have you ever had to take an antibiotic Pre-Med before a dental appointment?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco products? If so, how long?	Yes No	If yes

Women: Are you...

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

Are you allergic to any of the following?

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

Other? ☐ If yes

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

AIDS/HIV Positive Yes No	Diabetes Yes No	Hepatitis B or C Yes No	Psychiatric Care Yes No
Alzheimer's Disease Yes No	Drug Addiction Yes No	Herpes Yes No	Radiation Treatments Yes No
Anaphylaxis Yes No	Emphysema Yes No	High Blood Pressure Yes No	Renal Dialysis Yes No
Anemia Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Rheumatic Fever Yes No
Angina Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Fainting Spells/Dizziness Yes No	Hypoglycemia Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Frequent Cough Yes No	Irregular Heartbeat Yes No	Shingles Yes No
Artificial Joint Yes No	Frequent Diarrhea Yes No	Kidney Problems Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Frequent Headaches Yes No	Leukemia Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Genital Herpes Yes No	Liver Disease Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Heart Attack/Failure Yes No	Low Blood Pressure Yes No	Stroke Yes No
Cancer Yes No	Heart Murmur Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Heart Pacemaker Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Trouble/Disease Yes No	Osteoporosis Yes No	Turberculosis Yes No
Cold Sores/Fever Blisters Yes No	HPV (Human Papilloma Virus) Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No		Parathyroid Disease Yes No	Ulcers Yes No
Cortisone Medicine Yes No	Hemophilia Yes No		
	Hepatitis A Yes No		

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

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

In Consideration of the treatment by the Doctor.
I undersigned jointly and severally understand and agree.
1)That the proceeding information is correct to the best of my knowledge.

2)That I am responsible for all fees relative to the professional services rendered under this agreement, that this may include me, my family or other individuals I authorize. That this agreement as it relates to my financial responsibility extends to all past, present and future services rendered by the Doctor and his staff to me, my family or other individuals I may have authorized. I recognize that insurance is a contract between the patient and the insurance company, and I agree that I will pay all charges under this agreement regardless of my insurance coverage. I may terminate my responsibility under this agreement by paying my account in full and giving written notice to the Doctor.

3)That I will pay all sums that are due and payable at the time of service. No oral agreements have been made and this agreement cannot be modified orally.

4)That I agree to pay interest at the rate of 18% annually on all balances over 90 days from the original due date, plus court costs and reasonable attorney's fees, with or without suit, incurred in collecting any past due balances and a collection fee equal to 50% of the outstanding balance.

5) The call you receive to remind you of upcoming appointments is a COURTESY CALL only. You are ultimately responsible to make your appointment. Failure to show will result in a fee due at your next appointment. I agree to pay a $50 no show fee or cancellation fee for an appointment canceled within 24 hours of scheduled appointment.

_____ *Date:* _____
Responsible Party Signature

_____
Patient's Name, Please Print