ARVADA DENTAL EXCELLENCE
WHERE YOUR SMILE MATTERS

Welcome to our dental family! We are honored that you have selected us to provide dental care for you and your family!

PATIENT INFORMATION

Patient First Name: _____ Middle Initial: _____ Last Name: _____ Preferred: _____
Birthdate: _____ Social Security Number: _____
Address: _____City:_____State:_____Zip:_____
Drivers License No.:_____ Issuance State: _____ Expiration Date: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-mail Address: _____
Would you like to receive text or email reminders? Text: YES NO Email: YES NO
If patient is a minor, give parent's or guardian's name: _____
Employer: _____
Occupation: _____
Spouse Name: _____Spouse Birthdate: _____
Spouse Social Security Number: _____ Spouse Employer: _____
Spouse Occupation: _____
How did you learn about our office? _____
If you were referred by someone, whom may we thank? _____

RESPONSIBLE PARTY / BILLING INFORMATION

☐**Same as above** ***Responsible party must be present to sign paperwork
Responsible Party Name: _____
Birthdate: _____ Social Security Number: _____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Relationship to patient: _____
Employer: _____Occupation:_____

INSURANCE INFORMATION

☐**No insurance? No problem! Ask us about our In-office Care plan!**
PLEASE HAVE YOUR DENTAL CARD AVAILABLE TO INSURE CLAIMS ARE SENT OUT PROPERLY. THANK YOU!
Insured's name: _____ Insured's Birthdate: _____
SSN / ID#:_____ Insurance Company: _____
Group Number: _____ Insurance Phone: _____
Claims Address: _____City_____State_____Zip_____
Do you have dual coverage? ☐ YES ☐NO
Insured's name: _____ Insured's Birthdate: _____
SSN / ID#:_____ Insurance Company: _____
Group Number: _____ Insurance Phone: _____
Claims Address: _____City_____State_____Zip_____

CONSENT FOR TREATMENT

I hereby authorize Arvada Dental Excellence to administer, and perform, any such treatment as x-rays, anesthetics, and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.
I authorize the release of any pertinent information relating to my dental claims and I hereby authorize my insurance benefits to be paid directly to Arvada Dental Excellence.
I understand that after initial x-rays and examination, I will be given an estimate of fees to cover my treatment. At that time financial arrangements will be made before treatment is rendered. I understand and acknowledge that I am ultimately responsible for all costs of my dental treatment.
Preferred method of payment: ☐Cash/Check ☐Visa/MasterCard/Discover ☐ Care Credit (Synchrony Bank)

Signature (Patient or parent for minor) _____Date:_____

MEDICAL HISTORY

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions as accurately as possible.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

(Please check any of the following which you have had or have at present.)

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ **Other** (please list below):

_____
_____
_____
_____

☐ **Artificial Joint – if checked, please answer all of the following questions**:

- What was replaced? _____
- When? _____
- Office name & telephone number where procedure was done:_____
- Doctor's name:_____
- Do you require antibiotics prior to dental treatment?: ☐ YES ☐NO
- If you answered "YES" above, did you take your pre-medication today?: ☐YES ☐NO
- Name and quantity of antibiotic taken:_____
- What time did you take it? _____

Are you **ALLERGIC** or have you ever experienced any reaction to the following?

☐Aspirin ☐Acrylic ☐Sulfa Drugs ☐Penicillin ☐Metal ☐Local Anesthetics
☐Codeine ☐Latex ☐Other (please list):_____

Are you taking any medications: (Please list name, dosage, and reason. If they do not all fit below, please continue on the back of this sheet)

_____
_____

Have you ever been given antibiotics before dental treatment?	☐YES	☐NO	
Have you recently consumed alcohol?	☐YES	☐NO	
Have you recently used recreational drugs?	☐YES	☐NO	
Have you ever been hospitalized or had a major operation?	☐YES	☐NO	If yes: _____
Have you ever had a serious head or neck injury?	☐YES	☐NO	If yes: _____
Are you under a physician's care now?	☐YES	☐NO	If yes:_____
Do you take, or have you taken, Phen-Fen or Redux?	☐YES	☐NO	If yes: _____
Have you ever taken Fosamax, Boniva, Actonel, or any other Medications containing biphosphonates?	☐YES	☐NO	If yes: _____
Are you on a special diet?	☐YES	☐NO	
Do you use tobacco?	☐YES	☐NO	
Are you pregnant or trying to get pregnant?	☐YES	☐NO	Due Date: _____

What is your pharmacy of choice? Pharmacy: _____ Location: _____ Ph# _____

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 (Patient or parent for minor) _____Date:_____

DENTAL HISTORY

Name of Previous Dentist and Location: _____ Date of Last Exam: _____

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot/cold liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores/lumps in or near your mouth?	☐	☐
Have you had any head, neck, or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Do you have a family history of, or have you ever been diagnosed with Sleep Apnea?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement: _____		
Have you ever had braces or other orthodontic treatment?	☐	☐
Would you like your teeth to be whiter?	☐	☐
If so, would you like to learn more about your options?	☐	☐

On a scale of 1-10 (10 being the best) how would you rate your smile?

1 2 3 4 5 6 7 8 9 10

If it's not already, how can we help you bring it back to a perfect 10? _____

What are your present dental concerns? _____

What are your dental expectations? _____

What can we do to make your visits with us exceptional? _____

NOTICE OF PRIVACY PRACTICES

OUR PROMISE!

Your information is safe in our office.

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA-Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed?
Why a Privacy Policy now?
Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

Please ask to obtain a copy of our privacy policy at anytime. This is also available on our website in the FAQ section.

Signature_____ I have read the privacy policy.

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OFFICE POLICIES

The undersigned patient has sought and/or obtained professional treatment and services from Arvada Dental Excellence.

By signing this form, the patient understands and agrees that the charges for professional services provided by Jason Ganong, DMD, ABGD, or any other employee on his staff, are due and payable in full on the date which services are rendered.

As a courtesy to our patients, we will bill your insurance company. However, we do require your **estimated co-payment or patient portion to be paid the day of service before treatment.** You are ultimately responsible for your account and if your insurance does not pay within 45 days from the date of service, or if for any reason the insurance company refuses to cover your services, you will be responsible to pay your balance in full.

CHANGING OR CANCELLING AN APPOINTMENT:

We require a 48 hour notice for all appointment cancellations. If you cannot keep your appointment and are unable to give us the required 48 hour notice, there will be a cancellation fee of $80.00, or the deposit that was paid to hold the appointment, due immediately. **Please be aware that any Monday appointment cancellations must be made by 12:00 PM the Friday before.**

Our fees are registered as usual and customary with the Denver Metro area. Some insurance companies set their own fee schedules which may not match our usual and customary fees for the city of Denver. The patient understands that the difference not paid by the insurance will be their responsibility. *While we strive to advocate for our patients, it is ultimately the patient's responsibility to be aware of how their dental insurance works.*

Accounts past due of 60 days or more will be subject to a $5.00 late charge, as well as a 1.75% interest fee for each month the payment is late until the outstanding balance is paid in full.

Our returned check fee is $30.00 per returned check.

Minors must be accompanied by an adult.

Parents, please have child care arranged for your dental appointments if necessary.

If the patient's account is assigned to our collections agency, the patient will be responsible for the entire account including collection fees, attorneys' fees, and legal fees which may be incurred in the collection of the account.

Patient or Guardian Signature_____Date_____

Witness_____