

BOULDER HILL DENTAL ASSOCIATES

Mark R. Commean, D.M.D.& Amita P. Raval, D.M.D.

Date: _____

Patient's Name _____ Date of Birth _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell # _____

SS # _____ E-Mail Address _____

Sex F M Single _____ Married _____ Widowed _____ Divorced _____

Name of parents, if under 18 _____

Have you or a family member ever been a patient in our office before? Y N

IF yes, list _____

Who may we thank for referring you to our office? _____

How long since last dental visit? _____ Former Dentist _____

Address _____ Phone # _____

FINANCIALLY RESPONSIBLE INDIVIDUAL: (if same as above start at employed by)

Name _____ Address _____

City _____ State _____ Zip _____ Date of Birth _____

Home Phone _____ SS # _____

Employed by _____ Occupation _____

Address _____ City _____ Work # _____

Spouse/Parent _____ Address _____

City _____ State _____ Zip _____ Date of Birth _____

Home Phone _____ Social Security _____

Employed by _____ Occupation _____

City _____ Work # _____

INSURANCE PLAN #1 Employer _____

Insurance Carrier _____ Phone _____

Address _____ City _____ Zip Code _____

Group # _____ Employee Name _____

Relationship to patient (circle one) Self Spouse Father Mother Step-Mother

Step-Father Other (explain) _____

INSURANCE PLAN #2 Employer _____

Insurance Carrier _____ Phone _____

Address _____ City _____ Zip Code _____

Group # _____ Employee Name _____

Relationship to patient (circle one) Self Spouse Father Mother Step- Mother

Step-Father Other (explain) _____

MEDICAL INFORMATION:

Physician's Name _____

Address _____ Phone _____

Date of Last Medical Exam _____ For what reason? _____

May we request health information if needed? (circle one) YES NO

CONSENT:

The undersigned hereby authorizes the doctor 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. I also authorize the doctor to perform treatment, dispense medication, and provide therapy that may be indicated and further authorize and consent that the doctor choose and employ such assistance as he/she deems fit. I also understand use of anesthetic agents embodies a certain risk.

FINANCIAL POLICY:

We have worked hard to develop the following financial options. We want to make sure every one of our patients has the opportunity to receive the dental care they need and deserve, no matter what your financial situation may be. Your dental treatment is a valuable investment in your overall health and psychological well being. *Please keep in mind, we are always here if you have any questions or concerns and we will do our best to assist you in any way that we can.*

PAYMENT OPTIONS AND DISCOUNTS:

1. We offer our Senior Citizens 65 and over, a 10% discount at the time of service.
2. If you pay your portion at the time of service and pay by cash or check you will receive a 5% discount.
3. If you have dental work completed that involves the lab (denture, partial, crown, etc...) you must pay ½ of your estimated portion at start of treatment and the remaining balance at delivery appointment. If there are several appointments involved, you have the option of dividing your portion by the number of appointments, and paying at each appointment. Balance must be paid in full at time of delivery.
4. If your patient portion is over \$300, you have the option of putting down 50% initially and then making payments to pay off the balance over a 90 day period without accruing interest. (Regular monthly payments must be made)
5. We offer interest free payments up to one year for those who qualify through our 3rd party financing company, *Capital One Healthcare Finance*.

Your estimated patient portion is expected at the time of treatment. The patient portion is only an estimation, and only after we receive correspondence from your insurance will we know your actual cost. After 90 days, however, if the balance remains unpaid by your insurance, it then becomes your responsibility. Finance charges will accrue on all balances unpaid over 90 days. We charge a \$75 fee for cancellations made less than 24 hours prior to appointment. In the event of default I (We) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to collect payment of this note.

I agree to the above content.

Signed _____ 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.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

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

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 _____ DATE _____