

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 3<sup>rd</sup> 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**

FOR

12177--Crystal S. Hostetler (Crystal)

Birth Date: 3/30/1979

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 \_\_\_\_\_

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?  Nursing?  
 Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

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

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

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

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 \_\_\_\_\_