CENTRAL PARK MODERN DENTISTRY
7505 E 35th Ave #304• Denver, CO 80238
303-785-8991

Patient Information

Name: _____
Last First Middle

E-Mail Address: _____ Gender: Male_____Female_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____ Driver's License or ID Number:_____
MM / DD / YYYY

Responsible Party Information (If Patient is a Dependent)

Name: _____
Last First Middle

Relationship to Patient: _____ E-Mail Address: _____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth: _____/___/_____ Social Security Number: _____-____-_____ Driver's License or ID Number:_____
MM / DD / YYYY

Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: _____
Last First Middle

Primary Policy Holder's Date of Birth: _____/___/_____ Primary Policy Holder's SS/ Member ID Number: _____-____-_____
MM / DD / YYYY
Primary Policy Holder's Employer:_____

Insurance Company Name:_____ Group Number:_____ Insurance Company Phone: (____)_____

Insurance Company Address:_____
Street City State Zip

Emergency Contact Information

Local Friend or Relative not Living With You: _____ Emergency Contact Phone: (____)_____

Emergency Contact Address:_____
Street City State Zip

Getting to Know You

Why did you select our office? _____ Whom May we thank for referring you?_____

Is another member of your family already a patient with our practice? ❑ Yes ❑ No Family Member?_____

When was your last dental visit? _____

When was the last time you had complete dental x-rays taken? _____ Have you ever had any teeth removed? _____

How long have these teeth been missing? _____

How Have these teeth been replaced? ❑ Bridge ❑ Partial ❑ Denture ❑ Implants ❑They have not been replaced

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

_____

SIGNATURE OF RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT** **DATE**

CENTRAL PARK MODERN DENTISTRY

HEALTH HISTORY

Name:_____ Date: _____

Birth Date _____ Height _____ Weight _____ Age _____ Gender: ☐ M ☐ F

Please list all medical problems you are currently being treated for: _____

Please list all of your previous surgeries: _____

Please list any drug, food or latex allergies: _____

Please list your current medications: including aspirin or any other over the counter medications: _____

DO YOU HAVE, OR HAVE YOU EVER HAD….

☐ Yes ☐ No Chest pain	☐ Yes ☐ No Tuberculosis	☐ Yes ☐ No Bleeding/blood clot problems
☐ Yes ☐ No Heart attack	☐ Yes ☐ No Tobacco use	☐ Yes ☐ No Anesthetic problems
☐ Yes ☐ No Irregular heart beat	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Epilepsy/seizures
☐ Yes ☐ No Pacemaker/defibrillator	☐ Yes ☐ No Liver disease	☐ Yes ☐ No Glaucoma/eye problems
☐ Yes ☐ No Heart murmur	☐ Yes ☐ No Kidney disease	☐ Yes ☐ No Ulcers/gastric reflux
☐ Yes ☐ No Angioplasty/bypass	☐ Yes ☐ No Thyroid disease	☐ Yes ☐ No History of alcohol or drug abuse
☐ Yes ☐ No High blood pressure	☐ Yes ☐ No Rheumatic fever	☐ Yes ☐ No Currently pregnant/nursing
☐ Yes ☐ No Heart valve replacement	☐ Yes ☐ No Immune system problems	☐ Yes ☐ No Hip/knee/joint replacement
☐ Yes ☐ No Asthma	☐ Yes ☐ No Hepatitis/jaundice	☐ Yes ☐ No Blood thinners
☐ Yes ☐ No Shortness of breath	☐ Yes ☐ No Cancer	☐ Yes ☐ No Bone density medication
☐ Yes ☐ No Emphysema/COPD	☐ Yes ☐ No Chemotherapy	☐ Yes ☐ No Require antibiotics prior to surgery
☐ Yes ☐ No Sleep apnea	☐ Yes ☐ No Radiation therapy	

DENTAL HISTORY (PLEASE CHECK ALL THAT APPLY):

☐ Routine care only	○ Orthodontics	Jaw/tooth trauma	TMJ problems	Jaw surgery
☐ Gum disease	☐ Cancer	☐ Mouth sores	☐ Dental implants	☐ Dentures
	☐	☐	☐	☐

Please list anything else about your medical or dental history we should know: _____

_____ Signature-Patient/Guardian

_____ Dr's initials

UPDATED:_____ **DATE:** _____

Our goal is to make your experience in our office exactly how <u>you</u> want it to be. Please take a few moments and complete this profile so we can be of service to you as comfortable as possible.

1. Please rate the following statements regarding what is most important to you in dental care so we can best serve you: (#1 being the most important)

   ____Long-Term Preventative Care…I have healthy teeth and want to keep them that way.

   ____Creating a Comprehensive Overall Dental Care Plan…I want to Invest in my Teeth and Appearance

   ____Dental Care is budget driven. I will have to plan financially for any treatment beyond my immediate needs.

   ____ Other Goals: _____

2. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)

   1 2 3 4 5 6 7 8 9 10

3. Are you concerned about: (please circle yes or no)

Replacing missing teeth	Yes	No	Straightness of your teeth or bite	Yes	No
Eliminating any cavities	Yes	No	Snoring at night	Yes	No
Gum disease	Yes	No	Color of your teeth	Yes	No
Bad breath	Yes	No	Appearance of your smile	Yes	No

4. Are you or anyone in your family interested in a **complimentary** orthodontic (Braces or Invisalign) consultation with our Orthodontist? Yes No

We know dental care can be very stressful for most people. Please share your concerns and past experiences to help guide us in serving you and your family more effectively.

5. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)

   1 2 3 4 5 6 7 8 9 10

6. When we review your treatment plan with you, would you like to know (please check one):

   ____I am a big picture type person; I prefer to review the plan looking at all the things that need to be done.

   ___I am a detail-oriented person, I prefer to approach each treatment step along the way.

7. Please briefly describe any bad dental experiences you have had:_____

_____

_____

_____

THANK YOU!

DENTAL INSURANCE POLICY

Central Park Modern Dentistry proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment**. **All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

----------PATIENT ACKNOWLEDGMENT AND AUTHORIZATION----------

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Central Park Modern Dentistry. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

APPOINTMENT DEPOSIT REQUIREMENT

Central Park Modern Dentistry requires a minimum $50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of $300.00 or more. The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Central Park Modern Dentistry requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject to our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature: _____ Date: _____

CANCELLATION POLICY

Central Park Modern Dentistry makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 48 hours notice if you are unable to keep your scheduled appointment**. **We reserve the right to charge a cancellation fee of $50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, _____, have had the opportunity to review Central Park Modern Dentistry Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____

CENTRAL PARK
MODERN DENTISTRY

Credit Card on File Policy

Thank you for choosing Central Park Modern Dentistry for your dental needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible.

To streamline our billing and payment system and to provide a seamless, convenient way for patients. to pay their bills Central Park Modern Dentistry will require all patients to keep an active credit card on file with us, effective January 1, 2021 We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card if they inform us of any patient responsibility. Circumstances, when your card would be charged, include but are not limited to missed or canceled appointments without 24-hour notice, co-payments, deductible, and coinsurance any non-covered services, and/or denial of services.

- Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing the amount of your total patient responsibility. You will typically receive the EOB before we do, so if you disagree with the patient responsibility balance owed, contact your insurance carrier immediately.

- When we receive the EOB, we notify you if you owe any remaining balance. We will charge your credit card 7 days after that notification.

If the credit card we have on file for you changes, please notify the office IMMEDIATELY by phone or email. We know credit card information changes frequently, including when a credit card expires. That is quite understandable. If we run your credit card and it is denied for any reason, we will contact you at the phone number you provided to identify a new payment method.

We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you were in our office.

If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the same card in a timely manner. We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave an HSA (Health Savings Account), or Flex Plan Card on File.

Email: _____

Print Name: _____ Date: _____

Signature: _____