Print Form

HighPointe Dental 9760 Grant St. Suite 100, Thornton, CO 80229 (720) 583-1425 www.highpointedental.com

Patient Information

Date:

Patient Name:

Last Name First Name MI Preferred Name

Phone:

Home Phone Mobile Phone Work Phone Ext. Best Time to Call

Social Security # Birth Date Family Status: ☐ Single ☐ Married ☐ Divorced Gender: ☐ Male ☐ Female

Preferred Appointment Times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address:

Street Apartment #

City State Zip Code

Email

Health Information

Date of Last Dental Visit: Reason for This Visit:

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Blood Disease	☐ Hay Fever	☐ Mental Disorders	☐ Sinus Problems	LIST MEDICATIONS
☐ Allergies	☐ Cancer	☐ Head Injuries	☐ Nervous Disorders	☐ Stomach Problems	
_____	☐ Diabetes	☐ Heart Disease	☐ Pacemaker	☐ Stroke	_____
_____	☐ Dizziness	☐ Heart Murmur	☐ Pregnancy	☐ Tuberculosis	
_____	☐ Epilepsy	☐ Hepatitis	Due Date:	☐ Tumors	_____
☐ Anemia	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Radiation Treatment	☐ Ulcers	
☐ Arthritis	☐ Fainting	☐ Jaundice	☐ Respiratory Problems	☐ Venereal Disease	_____
☐ Artificial Joints	☐ Glaucoma	☐ Kidney Disease	☐ Rheumatic Fever	☐ Codeine Allergy	
☐ Asthma	☐ Growths	☐ Liver Disease	☐ Rheumatism	☐ Penicillin Allergy	_____

- Have you ever had any complications following dental treatments? ☐ Yes ☐ No

  If yes, please explain:

- Have you ever been admitted t a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

  If yes, please explain:

- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain:

  Name of Physician: Phone:

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain:

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

➡Sign Here:

Signature of Patient, Parent or Guardian Date

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient, Friend ☐ Another Patient, Relative ☐ Dental Office

☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice:

Print Form

HighPointe Dental 9760 Grant St. Suite 100, Thornton, CO 80229 (720) 583-1425 www.highpointedental.com

Spouse or Responsible Party Information

The Following is for: ☐ The Patient's Spouse ☐ The Person Responsible for Payment

Name: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Child ☐ Other _____

Phone: _____

Home Phone Mobile Phone Work Phone Ext. Best Time to Call Social Security # Birth Date

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The Following is for: ☐ The Patient ☐ The Person Responsible for Payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Is Insured a Patient? ☐ Yes ☐ No

Name of Insured: _____

Last Name First Name MI

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____ Insurance Plan Name: _____

Address: _____ Address: _____

Street Street

_____ _____

City State Zip Code City State Zip Code

Secondary

Is Insured a Patient? ☐ Yes ☐ No

Name of Insured: _____

Last Name First Name MI

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____ Insurance Plan Name: _____

Address: _____ Address: _____

Street Street

_____ _____

City State Zip Code City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

➡ _____

Signature of Patient, Parent or Guardian Date Relationship to Patient

➡ _____

Signature of Guarantor of Payment/Responsible Party Date Relationship to Patient

To Finish Print Form

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____, have received a copy of this office's Notice of Privacy Practices.
{Please Print Name}

_____
{Signature}

_____
{Date}

HIPPA Release Authorization

I, _____ give Highpointe Dental permission to leave a message on my phone at the following number _____.

I give Highpointe Dental permission to discuss my dental treatment with _____. Relationship to patient _____.

Signature _____

Date _____