BOULDER PREMIER
DENTISTRY

Welcome to our practice!

Today's Date ___________________

First Name __________________________Last Name ________________________________

Birth Date ________________ Age _________Social Security # _________________________

Address ____

Street City State Zip

Home Phone ____________________Work Phone ___________________________________

Cell Phone ______________________Email ____

Current dental insurance information, if we will be helping file claims for you:

Subscriber's Name & DOB ____

Subscriber's SS# ____

Subscriber's Address ____

Employer____

Insurance Carrier ____

Secondary Insurance?____

Group # ____

Name of previous Dentist ____

Date of last visit ____

Please Answer the following questions about your dental history

- Currently pre-medicate before dental appointments? □Yes □No
  Due to (circle one): Artificial Joints, Prosthetic Heart Valves, Other
- Are you dissatisfied with the appearance of your smile?_______________________
- If you could change one thing about your smile, what would it be?
  ____
- If we could offer you a simple and inexpensive way to whiten your teeth would you be interested?_________________
- How would you like your teeth to look in 15 years?
  ____
- Do you feel nervous about dental treatment?________________________________
- What can we do to alleviate your nervousness?______________________________
- Have you ever had a bad experience in a dental office?_______________________
- What can we do to make this experience better for you?
  ____
- Do you have sensitive teeth?____
- Does food trap between your teeth____

Whom may we thank for referring you to our office?

□Walk In □Ins. Website □Online Search □Mailer □Other

____

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 taking the time to answer the following questions:

Are you currently under a physician's care? □Yes □No
If yes, please explain: ____

Have you ever been hospitalized or had a major surgery? □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 use tobacco of any type? □Yes □No
If yes, please explain:____

Are you **ALLERGIC** to any of the following?

□Aspirin □Penicillin □Codeine □Acrylic □Metals □Latex □Sulfa Drugs
□Local Anesthetics □Other
If yes, please explain: ____

Women:

Are you pregnant or trying to get pregnant? □Yes □No
Are you taking oral contraceptives? □Yes □No
Are you currently nursing? □Yes □No
Have you ever been diagnosed with cervical dysplasia?□Yes □No

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

AIDs/HIV Positive	□Yes □No	Excessive Bleeding	□Yes □No
Alzheimer's Disease	□Yes □No	Fainting Spells/Dizziness	□Yes □No
Anaphylaxis	□Yes □No	Glaucoma	□Yes □No
Anemia	□Yes □No	Heart Attack/Failure	□Yes □No
Arthritis / Gout	□Yes □No	Heart Murmur	□Yes □No
Artificial Heart Valve	□Yes □No	Heart Pace Maker	□Yes □No
Artificial Joint	□Yes □No	Heart Trouble / Disease	□Yes □No
Asthma	□Yes □No	Hemophilia	□Yes □No
Blood Disease/Disorder	□Yes □No	Hepatitis A, B or C	□Yes □No
Breathing Problems	□Yes □No	High Blood Pressure	□Yes □No
Bruise Easily	□Yes □No	Kidney Problems	□Yes □No
Cancer	□Yes □No	Liver Disease	□Yes □No
Chemotherapy	□Yes □No	Low Blood Pressure	□Yes □No
Chest Pains	□Yes □No	Lung Disease	□Yes □No
Cold Sores/Fever Blisters	□Yes□No	Psychiatric Care	□Yes □No
Congenital Heart Disorder	□Yes□No	Radiation Treatment	□Yes □No
Convulsions	□Yes □No	Sickle Cell Disease	□Yes □No
Diabetes	□Yes □No	Intestinal Disease	□Yes □No
Drug Addiction	□Yes □No	Stroke	□Yes □No
Emphysema	□Yes □No	Thyroid Disease	□Yes □No
Epilepsy or Seizures	□Yes □No	Tuberculosis	□Yes □No

Any serious illnesses not listed above? ____

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 my dependent's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: ____

Date: _________________

Occlusal Screening

	YES	NO
1. Do you clench or grind your teeth during the day ?	____	____
2. Have you been made aware of clenching or grinding your teeth during sleep?	____	____
3. Do you have chronic headaches, neck, or shoulder pain?	____	____
4. Are your teeth or jaws tired when you awaken?	____	____
5. Have you ever had pain in your jaw joints, sides of of your face, or ears?	____	____
6. Has your jaw ever clicked or popped when you open your mouth?	____	____
7. Have you ever experienced difficulty moving your jaw or opening your mouth wide?	____	____
8. Do you chew on only one side of your mouth?	____	____

BOULDER PREMIER

DENTISTRY

Financial Policy

We are pleased that you have selected us as your dental care provider. For you knowledge, our Financial Policy is outlined below.

Promise to pay: Amounts for dental care services provided to you or your family members may be charged to your account. You promise to pay us all amounts owed on your account (your balance) under the terms of this Financial Policy. If you have insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with an insurance claim; however, insurance is a contract between the you and the insurance company. The anticipated amount to be paid by your insurance company will be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your account is your full responsibility. We may also charge to your account fees set forth below for missed appointments, late payments, returned payment or collection costs. I understand that I am responsible for all fee's related to my care. I understand that full payment/copay for all dental treatment done is to be paid when it has been performed.

Missed Appointment Fee: We may charge your account fees up to ***$100.00 per scheduled hour for a missed appointment or fees for an appointment canceled without advance notice of at least 2 business days notice.***

Late Payment Fee: If we do not receive payment in full of your balance **within 60 days** of the statement date shown on your statement, you will **be assessed a late payment fee of 2.50% of your unpaid balance each month**. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your balance.

Returned Payment Fee: If any check or other payment that you have made on your account is returned unpaid, you will be charged a returned payment fee, which is currently $75.00 and may be adjusted.

Collection Costs: If we do not receive payment under the terms of this financial policy and we refer your account to a collection agency or an attorney for collection, we may charge to your account or otherwise collect from you our collection cost, including court costs and reasonable attorneys' fees, to the extent not prohibited by applicable law.

No waiver by us: We may waive our right to charge a fee to your account without waiving any other right we have under this financial policy including our right to charge that same fee at any other time.

As used in this financial policy, "we", "us", "our", and "provider" mean the service provider named above. "Services" means any services provided by us. "You", "your", and "account holder" mean the person responsible for paying for services. Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your "account") as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this financial policy.

Yes, I agree to the above terms and conditions.

____________________________/____________________________/__________________

Account Holders Signature | Print Name | Date

No, I am not interested in establishing an account and therefore understand that full payment for dental care services is due at the time of appointment.

____________________________/____________________________/__________________

Account Holders Signature | Print Name | Date