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WELCOME

Thank you for joining our periodontal practice. We appreciate your confidence in us and we will do everything possible to provide you with the finest periodontal care. Please fill out the following pages and ask if you have any questions.

PATIENT INFORMA	TION	TODAY'S	DATE
LAST NAME	FIRST	M.I.	NICKNAME
STREET NUMBER & NAME	CITY	& STATE	ZIP CODE
HOME PHONE NUMBER	BUSINESS PH	ONE NUMBER	CELL PHONE NUMBER
EMAIL ADDRESS	SOCIAL SECU	RITY NUMBER	DATE OF BIRTH - AGI
			FEMALE / MALE / OTHE
BUSINESS NAME	OCCUPATION		SEX
REFERRED BY WHOM: (name of	dentist, or friend)		
EMERGENCY CONTA	ACT		
NAME	TELEPHONE		RELATIONSHIP

MEDICAL HISTORY	M	EDICAL UPDA	TES	
Personal Physician's Name:	DATE	CHANGE	MEDS	
	-			
Phone Number: Please list any serious medical problems or surgeries you have				
had:				
Please list any medications that you are now taking:				
Do you smoke? □YES □NO Use Marijuana? □YES □NO WEIGHT: HEIGHT WOMAN: Are you pregnant? □YES □NO Taking contraceptives? □YES □NO				
Do you have or have you had any of the following:				
Artificial Joints Anemia				
Artificial Heart ValveAids/HIV+				
Circulatory ProblemsCancer Drug/Alcohol AbuseDiabetes				
Heart Murmur Hepatitis A, B or other				
High Blood PressureHerpes				
Low Blood PressureKidney problems				
Nervous ProblemsPanic attacksRadiation TreatmentRheumatic fever				
smas proteins				
Please tell us about any current medical condition, NOT listed				
above, which may possibly affect your dental				
treatment:				
Are you allergic to any of the following medications: (please				
check all that apply).				
Penicillin Aspirin Ibuprofen				
Clindamycin Codeine Acetaminophen Dental Anesthetics OTHER:				
DENTAL HISTORY				
DENIAL HISTORI				
Family Dentist				
Family DentistHow long have you been a patient in that office?				
Reason for today's visit:				
Have you ever had gum treatment?NOYes				
Deep cleaning? Date (YR):Gum Surgery Date:				
I understand that the information that I have given today is				
correct to the best of my knowledge. I also understand that this				
information will be held in the strictest confidence and it is my				
responsibility to inform this office of any changes in my				
medical or dental status.				
Signature Date				

Statement of Financial Policy

Please initial and sign, indicating your understanding of the following information. If you have questions, please do not hesitate to ask. It is important that you understand these specific policies of Colorado Gum Care.

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It is your responsibility to provide the office with current and correct insurance information. Failure to do so could result in your insurance company rejecting your claims for failure to obtain authorization or timely filing. In the event that this should happen you will be responsible for the incurred charges.
We do not always know if you have a deductible, if your deductible has been met or if you have co-insurance. It is your responsibility to know this information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible or co-insurance.
If you have a co-pay or and/or <u>estimated</u> patient portion, you are expected to pay this when you check in for your visits. Most insurance companies assign a patient portion to recall appointments and operative visits. It is our responsibility to collect this at the time of service. We accept cash, checks, money orders, Visa, Master Card, Discover and American Express. Be prepared to pay when you check in for each visit.
You will be charged a \$75.00-\$150.00 fee if you fail to show up for your appointment or if you cancel your appointment without proper notice.
We do offer financial arrangements with a 10% processing fee added up front. We also accept Care Credit and Lending Club.
A pre-determination of benefits will only be sent to the insurance at your request.
A non-refundable deposit will be required when scheduling IV sedation cases and any surgical appointments at the doctors request.
I understand that I am responsible for all costs of collection including attorney fee collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly).
I hereby authorize this Colorado Gum Care and its employees, agents, and assigned to contact me via e-mail and text messaging, and to my cellular devices.
I consent to Credit Control Agency and its assignees to communicate with me by telephone, e-mail, fax, or other means.
Patient or Guardian Date

Cancellation Policy

Colorado Gum Care strives to deliver excellent dental care to all of our patients. In order to be consistent with this philosophy, we have implemented the following appointment cancellation policy:

Surgical Visits

We request that you give our office a seven day notice in the event that you need to reschedule or cancel your procedure with the dentist. This includes all treatment visits with the dentist. If you miss an appointment for the surgical visit without providing us with the proper notice, we will consider this to be a missed appointment and a \$150.00 fee may be assessed to reschedule your appointment. This fee will not be applied to your rescheduled procedure.

Office visits and Cleanings

We request that you give our office at least two full business days' notice in the event that you need to reschedule or cancel your appointment with the dentist or hygienist. If you miss an appointment for the office visit without providing us with the proper notice, we will consider this to be a missed appointment and a \$75.00 fee may be assessed to reschedule your appointment. This fee will not be applied to your rescheduled procedure.

As a courtesy, we do make reminder calls, texts and/or e-mails 10 days prior to your appointment. We will also contact you to confirm your appointment 3 days prior. If you do not receive your messages or we have incorrect information, the cancellation policy will still be in effect.

Patient or Guardian	Date



Pharmacy information Sheet

Patient Name:	Date:
Pharmacy Name	
Pharmacy Phone:	
Pharmacy Address	
City	Zip