

ASPEN FAMILY DENTAL

Thank you for selecting us to provide for your oral health needs. We promise our best in providing you with Excellence, Value, and Care in dentistry. We hope to be an office that you love and would refer your family and friends to. Please let us know if there is anything we can to improve your experience.

Referral Information (What brought you to visit us?)

Referral (who?) _____ Location _____
 Advertisement (which one?) _____ Other (please describe?) _____

Patient Information

Full Name: _____ Preferred Name: _____
Birth date: _____ SS#: _____
Employer: _____ Work Phone: _____
Wireless Phone: _____
 Married, Single, Child, Widowed, Divorced

Household Information (You only need to complete this section once per family. All fields are required)

Guardian/Guarantor: _____ Relationship: _____
Email (appt. reminder/bills, please fill in as this is very helpful): _____
Employer: _____ Work Phone: _____
Home Address: _____
City: _____ State: _____ Zip code: _____
Home Phone: _____ Wireless Phone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information (Make sure we make a copy of your primary and secondary insurance cards)

Subscriber's Name: _____
SS#: _____ Subscriber's Birthday: _____

Office Policies

Warranty

We guarantee all of our work and will replace anything resulting from technique or material error at no cost to you if you maintain regular 6 month maintenance visits and complete all necessary work. Not doing these things will jeopardize the success of the work we perform. We offer this because we use the best materials and techniques available.

Privacy Policy

We are committed to keeping all of your information private and will not discuss or share personal information except with those authorized by you. We shred and properly dispose of all documents that have any personal information on them. Your email is kept private. We fully comply with all provisions of HIPAA (Health Insurance Portability and Accountability Act of 1996).

Consent to Procedures

You authorize Dr. Robert M. Baird, Dr. Nathan C. Johnson, and/or the staff at Aspen Family Dental to perform those procedures agreed upon and within the standard of care on you (or at your request, to your minor child or ward). We commit to informing you about all procedures. We encourage you to diligently ask us if you have any questions about any procedures or their necessity, for we want you completely comfortable through the entire process.

Payment Policy

- You agree to be responsible for your own dental bill. We will do our best to help bill your insurance, but you are responsible if they do not cover services performed.
- All copayments (or entire fee for customers without insurance) are due at beginning of apt.
- You will receive a 10% discount if you pay your entire portion of the treatment plan before treatment begins after having a comprehensive exam (Only for patient portions over \$1000).
- We accept cash, credit cards, and checks.
- We offer 0% interest for 12 months financing through Care Credit.
- We charge \$40 for all missed appointments w/o 48 hr notice or if appointment canceled because of inability to pay at time of service.
- You agree to pay any late fees assessed if your account becomes past due, and agree to pay a 35% collection fee on any unpaid balance along w/ all attorney's fees and court costs if your account must be turned over to collections.

Signature: _____ Date: _____ Relationship to Patient: _____

Health History

Physicians name: _____ Phone: _____

Yes No

- 1. Have you been under a physicians care or had any health problems in recent years?
If yes, explain _____
- 2. Please list name and purpose of any medications you currently take _____
- 3. Have any allergies? Latex, Antibiotics, Metal, Local Anesthetic,
 Other (explain) _____
- 4. (Women) Are you pregnant or trying to get pregnant?
- 5. Do you have any pain now? _____
- 6. Does the dental treatment make you nervous?
- 7. Are you interested in cosmetic procedures (bleaching, veneers) ?
- 8. Are you interested in braces or Invisalign (adults and youth)?
- 9. Do you want missing teeth replaced?
- 10. When was your last dental visit? _____
- 11. Other information the dentist should know _____

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

Yes No

- Heart problems _____
- Blood disorders _____
- High Blood Pressure
- Angina/Chest Pain
- Heart Attack (when?) _____
- Stroke (when?) _____
- Require antibiotic premedication
- Rheumatic Fever
- Artificial heart valves
- Pacemaker
- Artificial joints (where?) _____
- Bruise easily
- Hepatitis or liver disease
Type? _____
- HIV or AIDS
- Cancer (type?) _____

Yes No

- Asthma (last attack?) _____
- Diabetes (type?) _____
- Tuberculosis (when?) _____
- Psychiatric treatment _____
- Kidney Disease
- Fainting or Seizures
- Arthritis (type?) _____
- Tobacco products _____
- Alcohol (how often?) _____
- Recreational drugs (i.e. narcotics)
- Take Medications for Osteoporosis
- Click in jaw
- Migraine/ Headaches
- Cold sores/ Mouth Ulcers
- Dry Mouth, typical w/ medications
- Other, _____

I hereby certify that my answers to the forgoing questions are accurate. Since a change in my medical conditions or medications can affect dental treatment, I agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)

Payment Options

Please be aware this is an estimate only. Coverage with insurance may be less than estimated or work needed may change. **Please feel no pressure to schedule work until you are ready to pay to have it performed.**

Please choose one of the following,

_____ I will pay my estimated portion in full at the **beginning** of each visit (*This is the default option if form is not signed*).

_____ I want to make no interest payments to CareCredit (3, 6, or 12 month, must be approved before first visit).

_____ I want an additional 10% discount by prepaying for all work on Treatment Plan before beginning. (*Discount only applicable after comprehensive exam and only on patient portions over \$1000*).

By signing below, I agree:

- to pay according to payment option chosen above,
- to pay **broken appointment w/o 48 hr notice fee of \$40 (*including canceling appointment because of inability to pay*)**, and
- to pay past due account fees if applicable.
- to pay a 35% collection fee on any unpaid balance along w/ all attorneys' fees and court costs if my account must be turned over to collections.

Signature of patient or guardian

Date

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ASPEN  *FAMILY*
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