

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 and hope to become a dentist that you love and would refer you family and friends to.

Referral Information (What convinced you to visit us?)

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

Patient Information

Full Name: _____
Preferred Name: _____ Birth date: _____
SS#: _____ Email (appt. reminder/bills ect.): _____
Employer: _____
Wireless Phone: _____
Work Phone: _____
 Married, Single, Child, Widowed, Divorced

Household Information (You only need to complete this section once per family)

Home Address: _____
City: _____ State: _____ Zip code: _____
Home 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

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, 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 time of service.**
- You will receive a **10% discount** if you pay your entire portion of the treatment plan before treatment begins.
- We accept cash, credit cards, and checks.
- We offer **0% interest for 12 months** financing through Care Credit.
- **We charge \$35 for all missed appointments without 24 hr or reasonable advance notice.**

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, Sulfa Drugs, 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?) _____
- Told you require antibiotic
Premedication
- Rheumatic Fever
- Artificial heart valves
- Pacemaker
- Artificial joints (where?) _____
- Bruise easily
- Hepatitis or liver disease
Type? _____

Yes No

- HIV or AIDS
- Cancer (type?) _____
- 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
- 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)