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Bob Johnson, DDS

# Patient Information

**Name:**_____ **Preferred Name:** _____**Date:** _____

**Address:** _____
**street** **city** **state** **zip**

**Please provide all contact information, and then check best method of contact during working hours:**

**___ Home Phone:** _____ **____ Cell Phone:** _____

**___ Work Phone:** _____ **____ E-Mail Address:** _____

**Birthdate:** _____ **Social Security #** _____

**If patient is a minor, give parent's or guardian's name:** _____

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**Responsible Party**

**Person responsible for Account, if different than above:** _____

**Address:** _____
**street** **city** **state** **zip**

**Social Security #:** _____ **Birthdate:** _____

**Relationship to Patient:** _____ **Employer:** _____

**Occupation:** _____ **Years Employed:** _____

**Spouse's Name ( if applicable) :** _____ **Birthdate:** _____

**Spouse Contact #:** _____

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**Emergency Contact Information**

**Emergency Contact Name:** _____ **Relationship:** _____

**Phone Number:**_____

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**Do other members of your family come here with the same insurance? ___No ___Yes - Who?** _____

**Whom may we thank for referring you to our office?** _____

**If referred by the internet, which source? (check one) ____ Google Search ____ Social Media ____ Our website**

**___ Radio ___ Other (please specify)** _____

*I hereby authorize payment directly to Bob Johnson, DDS, of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I acknowledge the opportunity to review this office's privacy policy. The information on this page is correct to my knowledge.*

***Signature:*** _____ **|** ***___Check if not patient signing : Relationship:***

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# Dental Insurance Information

**Please Check One:**

**___ I don't have dental insurance - Just sign the bottom**

**___ I have State-Sponsored insurance - This includes both Medicaid and Health First Colorado**

> **-> If you have State-Sponsored insurance for medical or dental insurance, unfortunately we will be unable to provide service to you as we are not a certified Medicaid provider. Please let the front desk know, or give us a call at (970)245-3633 so we can answer any questions you may have.**

**___ I have another dental insurance**

> **What company is your dental insurance through?**
>
> **___ Aetna ___Anthem ___Blue Cross Blue Shield ___Delta Dental ___Humana**
>
> **___MetLife ___United Healthcare ___Other: Please Specify - _____**
>
> **If your dental insurance is through an employer, who is that employer?**
>
> **_____**

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**PRIMARY DENTAL INSURANCE HOLDER**

**Insured's Name (Subscriber of Insurance) : _____**

**Insured's Social Security #:_____**

**Insured's Birth date: _____**

**Insurance Company: _____**

**Subscriber ID #: _____ Group #:_____**

**Insurance phone # : _____**

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**SECONDARY DENTAL INSURANCE (if applicable)**

**Insured's Name (Subscriber of secondary Insurance) : _____**

**Insured's Social Security #:_____**

**Insured's Birth date: _____**

**Secondary Insurance Employer (if applicable): _____**

**Insurance Company: _____**

**Subscriber ID #: _____ Group #:_____**

**Insurance phone # : _____**

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***By signing below I acknowledge that my insurance plan(s) is(are) an agreement between me and my insurance provider. I am responsible for any balance that is not covered by my insurance providers(s).***

***Signature: _____ | ___Check if not patient signing : Relationship:***

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## MEDICAL HISTORY

**Patient Name:** _____ **Birthdate:**_____

Physician Name: _____ Last Seen Date: _____

**Have you ever had any of the following medical conditions?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Acid Reflux/GERD | | A-Fib | | Alzheimers, Dementia | | Anemia |
| | Angina/Chest Pain | | Anti-depression Meds | | Arthritis | | Artificial Joints |
| | Asthma | | Autoimmune Compromised | | Blood Disease | | Bruises easiy |
| | Cancer | | Chemotherapy | | Diabetes | | Dialysis |
| | Drug abuser | | Epilepsy | | Excessive Bleeding | | Fainting/Dizziness |
| | Fosamax Related Med | | Frequent Cough | | Glaucoma | | Hayfever |
| | Head Injuries | | Heart Attack | | Heart Disease | | Heart Murmur |
| | Heart Surgery | | Heart Valve Replaced | | Hepatitis | | Herpes/Cold Sores |
| | High Blood Pressure | | HIV | | Hypoglycemia | | Hypothyroidism |
| | Irregular Heartbeat | | Jaundice | | Jaw Pain | | Kidney Trouble |
| | Leukemia | | Liver Disease | | Low Blood Pressure | | Lung Disease/Breathing |
| | Lupus | | Mental Disorders | | Mitral Valve Prolapse | | Murmur - no pre med |
| | Nervousness | | Pacemaker | | Pregnant | | Premedicate |
| | Psoriasis | | Psychiatric Care | | Radiation Treatment | | Raynaud's Disease |
| | Respiratory Problems | | Rheumatic Fever | | Rheumatoid Arthritis | | Seizures |
| | Sinus Problems | | Sjogrens | | Sleep Apnea | | Steroid Therapy |
| | Stomach/Intestinal Issues | | Stroke | | Sudden Weight Gain | | Sudden Weight Loss |
| | Tremors | | Tumors/Growths | | Ulcerative Colitis | | Ulcers |

Do you have any other condition you would like us to know about? _____ Yes _____ No

If yes please describe: _____

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**Are you allergic to any of the following Medications or substances?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Acrylic | | Aspirin | | Codeine | | Latex Rubber |
| | Metal: | | Penicillin | | | | |

**Have you ever had any of the following allergies?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Amoxicillin | | Anesthetic | | Anesthetics | | Bactrim |
| | Benadryl | | Caffeine | | Calcium-caltrate | | Cephalexin |
| | Diazepam | | Hydrocodone | | Ibuprofen | | Metronidazole |
| | Nsaids | | Opioids | | Pollen | | Sulfa |
| | Sulphites/Sulfites | | Tree Nuts | | Triazolam | | |

Do you have any other allergies? _____ Yes _____ No

If yes please describe: _____

Are you taking any medications, pills, or drugs? ___Yes ___No

Please list:_____

---

Have you been hospitalized or had a major operation? ___Yes ___No

If yes, for what condition? _____

Do you have any other condition(s) you would like us to know about? ___Yes _No

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WOMEN - Are you pregnant/trying to conceive? ___Yes ___No
WOMEN - Are you nursing? ___Yes ___No
WOMEN - Are you taking oral contraceptives? ___Yes ___No

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

Signature:_____ Date: _____

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# DENTAL RISK ASSESSMENT FORM

We see you every 6 months, you see you everyday.
-> This form helps us determine your risk for cavities and gum disease.

Please fill out the following to the best of your ability.

What was your recommended hygiene schedule at your previous office?
__ Every 6 months ___Every 4 months ___Every 3 months ___I don't know ___Other: _____

What type of toothbrush do you use?
___Manual ___Electric

Are your bristles: __Hard ___Medium ___Soft

How are you with flossing?

___Once Daily ___Once every other day ___Irregular flossing
___I'm supposed to floss? ___Other:

When you floss, do you use:

___String floss ___Flossing aid

Please check if the following applies to you:

__I use interproximal brushes

___I use an AIrFlosser/Waterpik

___I chew Xylitol/sugar free gum on a regular basis

___I wear a sleep apnea dental appliance

___I use a fluoride VARNISH

___I use a fluoride TOOTHPASTE - Is it prescription? ___Yes ___No

___I use a fluoride RINSE - Is it prescription? ___Yes ___No

___I use a fluoride GEL in trays

When it comes to teeth whitening:

___ I do not whiten my teeth ___I use custom trays ___I use OTC teeth whitening option
___I get in office teeth whitening

___ I wear a Night Guard

___It is an OTC NightGuard ___It is a custom made NightGuard

DAMAGING FACTORS

___ I tend to snack frequently

When I snack it is mostly:

___Carbs ___Veggies ___Fruit ___Nuts ___Other:_____

___I have a candy habit

___I have dry mouth

___I have acid reflus

___I have an acidic habit (I.e. Wine, soda, tea, energy drinks, La Croix, fizzy water)

What do you normally drink?_____

___ I smoke cigarettes

___I chew

___I vape with nicotine

___I have a family history of gum disease

___I have a family history of cavities

___I clench my teeth

___ Mostly day ___Mostly night

___I grind my teeth

___I have sleep apnea

Please list anything else that your think couple impact your oral health in a positive way:

Please list anything else that your think couple impact your oral health in a negative way:

Signature: _____ Date: _____

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# DENTAL HISTORY

**Patient Name: _____ Date:_____**

When was your last dental cleaning? _____

**Please mark yes or no to the following questions:**

| Yes | No | Question |
|---|---|---|

**General**

| | | |
|---|---|---|
| | | **Do your gums bleed when brushing, flossing, or eating?** |
| | | **Do you have difficulty brushing or flossing an area?** |
| | | **Does food collect between your teeth?** |
| | | **Do you have a bad taste or odor in your mouth?** |
| | | **Do you have any loose teeth?** |
| | | **Do you or have you ever smoked?** |
| --- | --- | **Packs / Day:** |
| --- | --- | **When did you quit (if applicable):** |
| | | **Have you ever been diagnosed or treated for periodontal disease?** |

**Pain/Injuries**

| | | |
|---|---|---|
| | | **Do you have toothaches, sore teeth, or dental pain?** |
| | | **Are your teeth sensitive to hot, cold, sweets, biting, or touch?** |
| | | **Do you have any broken teeth, missing fillings, or root canals?** |
| | | **Do you have soreness or pain in your jaw, ear, or side of your face?** |
| | | **Do you get frequent headaches?** |
| | | **Does your jaw ever pop, click, lock, or become fatigued or tired?** |
| | | **Do you have difficulty opening, closing, or chewing certain types of foods?** |
| | | **Do your teeth come together unevenly?** |
| | | **Have you had an injury to the head/neck, or had an auto accident?** |

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**Aesthetics/Appearance**

| | | |
|---|---|---|
| | | **Are you dissatisfied with the appearance of your teeth?** |
| | | **Do you have dental work which you consider ugly or less than ideal?** |
| | | **Do you have chips, spaces, crowded or crooked teeth that bother you?** |
| | | **Are you self-conscious of your teeth or smile?** |
| | | **Would you like to improve your smile?** |

**Experiences**

| | | |
|---|---|---|
| | | **Have you ever had any complications from past dental treatment?** |
| | | **Have you ever experienced any complications or reactions from local anesthetic?** |
| | | **Did you ever have braces or orthodontic treatment?** |
| | | **Do you have any lumps, sores, or growths in your mouth?** |
| | | **Does dental treatment cause you much worry or concern?** |
| | | **Have you ever had an unpleasant dental experience in the past?** |
| | | **Do you think your teeth are affecting your general health?** |

Signature:_____ Date: _____

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# Personal Health Information Disclosure Consent

Do we have permission to?
Send an appointment reminder and information to your home/text/email? Y__N__
Okay to leave the following information on your home/cell/voicemail:

Appointment information Y__N__
Billing information Y__N__
Dental/Medical information Y__N__

Information Sharing: Please list any individuals we can share your personal information with other than healthcare providers. *Please list at least 1 for an emergency contact (If you have not already given us one today)*

Name: _____ Relationship: _____ Number: _____

Name: _____ Relationship: _____ Number: _____

Name: _____ Relationship: _____ Number: _____

Information to be disclosed (please check):

- ☐ Appointment dates and times
- ☐ Treatment plans and referrals
- ☐ Financial and billing information
- ☐ Any other pertinent dental health information related to treatment at this office.

I understand that this permission will remain in effect unless a written cancellation has been provided to Horizon Dental Care.

Patient Signature:_____ Date:_____

Patients Date of Birth: _____

Witness Signature:_____ Date: _____

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# Horizon Dental Care Financial Policy

We try to make your dental care as cost-efficient as possible. One measure we have taken to keep costs down is to minimize our billing and accounting; therefore, we ask for payment/copayment in full at the time of service. Financial arrangements must be established before our office can proceed with any recommended treatment.

For patients with dental insurance coverage, our office will provide an estimated copayment total based on your dental coverage. This is an estimate and not a guarantee of benefits. If your carrier's payment differs from our estimate, you are financially responsible for the balance. In the case of an overpayment, you are entitled to a prompt refund. Any claims over 90 days, become your responsibility, and account will be due.

If after insurance pays, there remains a balance on your account, you will receive a Statement for Services. This is due and payable by the 31st of the month. We will continue to send a statement each month until the balance of your account is paid in full. There is a 2.5% per month late fee applied to account balances over 30 days old. Should your account become delinquent (past due), we will continue to send a statement until the balance is 90 days old. If your account remains delinquent, two consecutive statements will be sent in order to avoid the necessity of pursuing further collection actions. Should your account remain delinquent, we will forward the balance to our collection agency.

In cases of divorce or separation, the parent bringing the child is responsible for payment.

Cancellation Policy: If it becomes necessary to reschedule your appointment, we request the courtesy of 24 hours notice. If you cancel, do not show or miss your appointment without the required notice we will assess a $52.00 non-refundable missed appointment service charge. This fee is strictly enforced and will not be covered by your insurance.

If you have any questions regarding your account balance or if you are experiencing circumstances beyond your control, please contact our office. We will be happy to assist you with your questions or to set up special payment arrangements.

Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. Our team will make every effort to clarify any misunderstandings you may have concerning your account balance or our financial policies. We hope to avoid any possible disagreements over payment for professional services.

Our patients and our relationships with our patients are very important to us. If you have any questions or need assistance, please contact us immediately.

Printed Name: _____ Date: _____

Signed Name: _____

# Horizon Dental Care Privacy Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.
We understand that the privacy of your personal information is important to you. As your dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 970-245-3633.

**Information We Collect About You**

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect dental information regarding diagnosis, treatment plans, progress and any test results or films.

**How Your Information Is Used**

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Horizon Dental Care does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.
We may contact you to provide appointment reminders or information about treatment.

**Safeguarding Your Personal and Health Information**

We are required by law to
(1) make sure that medical information that identifies you is kept private
(2) provide you with our privacy policy
(3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Horizon Dental Care maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Horizon Dental Care

**Changes to Our Privacy Policy**

All new patients will review a copy of our privacy policy. Horizon Dental Care occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

**Your Right to Restrict Use of Information**

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Signed Name: _____ Date: _____