CASTLE PINES FAMILY DENTISTRY

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WELCOME TO OUR PRACTICE AND THANK YOU FOR TRUSTING US WITH YOUR DENTAL NEEDS!

PATIENT INFORMATION

Name ______________________________ Soc. Sec. # __________
Last First Initial

Address __________ City __________ State ______ Zip ______

Home Phone __________ Other Phone __________ Email address __________

Sex ☐ M ☐ F Age ______ Birthdate __________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer __________ Occupation __________

In case of emergency, who should be notified? __________ Phone __________

Whom may we thank for referring you? __________

FAMILY INFORMATION

Please list the names and birthdates of your immediate family members

Name __________ Birthdate __________

Name __________ Birthdate __________

Name __________ Birthdate __________

Name __________ Birthdate __________

INSURANCE INFORMATION

Person Responsible for Account __________

Relationship to Patient __________ Birthdate __________ Soc. Sec. # __________

Address (if different than patient's) __________ Phone __________

City __________ State ______ Zip ______

Person Responsible Employed by __________ Occupation __________

Business Address __________

Insurance Company __________

Contact # __________ Group # __________ Subscriber # __________

Names of other dependents covered under this plan __________

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, what is the subscriber's name? __________ Soc. Sec. # __________

Insurance Company __________

Contact # __________ Group # __________ Subscriber # __________

DENTAL HISTORY

Reason for today's visit __________ Date of last dental care __________

Previous Dentist __________ Date of last dental x-rays __________

Address __________

Check (√) if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping in jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweet
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you brush? __________ How often do you floss? __________

Additional questions or concerns __________

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MEDICAL HISTORY

Physician's name ______________________________ Date of last visit ____________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ____________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ____________

Have you ever taken any of the drugs collectively referred to as "fen-phen? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

If the patient is a child, what is his/her weight? ____________

Check (√) if you have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis/Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

MEDICATIONS

List any medications you are currently taking
(include over-the-counter pain reliever or allergy medication)

____

____

Pharmacy Name ____________ Phone ____________

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Local Anesthetic
☐ Latex
☐ Penicillin
☐ Sulfa
☐ Other ____________

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ____________ Signature ____________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with ____________

Name of Insurance Company(ies)

and assign directly to Dr. Stephanie Scheich or Dr. Jeff Scheich all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I have also read and understand this office's HIPAA policies and guidelines.

Date ____________ Signature ____________

MINOR/CHILD CONSENT

I, being the parent or guardian of ____________ do hereby request and authorize the

Name of minor/child

dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date ____________ Signature ____________

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date ____________ Signature ____________