Sedona Dental Office
905 W. 124th Ave. Suite 170
Westminster, CO 80234
303-452-3982

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name____Soc. Sec. #_____________________________

Last Name First Name Initial

Address____

City________________________State__________Zip___________Phone______________________________

Sex π M π F Age____Birthdate______________ π Single π Married π Widowed π Separated π Divorced

Patient Employed by_________________ Occupation______________E-mail__________________________

Business Address____Business Phone_______________________

Whom may we thank for referring you?_________________________Cell Phone_________________________

Notify in case of emergency_______________________Home Phone______________Work Phone___________

Primary Insurance

Person Responsible for Account____

Last Name First Name Initial

Relation to Patient___________________________Birthdate_____________Soc. Sec. #____________________

Address (*if different from patient*)____________________________________Home Phone__________________

City____State_________________Zip_________________________

Person Responsible Employed by_______________________________Occupation_________________________

Business Address____Business Phone______________________

Insurance Company____Phone_____________________________

Contract #___________________________Group #_______________Subscriber #_________________________

Name of other dependents under this plan____

Additional Insurance

Is patient covered by additional insurance? π Yes π No

Subscriber Name_____________________________Relation to Patient_____________Birthdate______________

Address (*if different from patient*)____Soc. Sec. #____________

City__________________________________State__________Zip___________Phone_______________________

Subscriber Employed by______________________________________Business Phone______________________

Insurance Company____Phone_____________________________

Contract #___________________________Group #_______________Subscriber #_________________________

Name of other dependents under this plan____

Please complete both sides.

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Dental History

What would you like us to do today?____________________Are you in dental discomfort today?______________
Former Dentist______________________________Address____________________________Phone_________
Date of last dental care_______________________________Date of last x-rays____________________________
Check if you have had problems with any of the following:

π Bad Breath	π Food Collection between teeth	π Periodontal treatment	π Sensitivity to sweets
π Bleeding Gums	π Grinding or clenching teeth	π Sensitivity to cold	π Sensitivity when biting
π Clicking or popping jaw	π Loose teeth or broken fillings	π Sensitivity to hot	π Sores or growths in mouth

How often do you brush?_____________________________________Floss? ____________________________
How do you feel about the appearance of your teeth?____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? π Y π N
Other information about your dental health or previous treatment____

Medical History

Physician's name____Phone______________________________
Date of last visit_________________________________Have you had any serious illnesses or operations? π Y π N
If yes, describe____
Are you currently under physician care? π Y π N If yes, describe_______________________________________
Have you ever had a blood transfusion? π Y π N If yes, give approximate date__________________________
Women: Are you pregnant? π Y π N Nursing? π Y π N Taking birth control pills? π Y π N
Check if you have had problems with any of the following:

π AIDS/HIV Positive	π Cough, persistent	π Hepatitis	π Rheumatic/Scarlet fever
π Anaphylaxis	π Cough up blood	π High Blood Pressure	π Shingles
π Anemia	π Diabetes	π Jaw Pain	π Shortness of breath
π Arthritis, Rheumatism	π Epilepsy	π Kidney disease or malfunction	π Skin Rash
π Artificial heart valves	π Fainting		π Spina Bifida
π Artificial joints	π Food allergies	π Liver disease	π Stroke
π Asthma	π Glaucoma	π Material allergies (**latex,** wool, metal, chemicals)	π Surgical implant
π Atopic (allergy prone)	π Headaches		π Swelling of feet or ankles
π Back problems	π Heart murmur	π Mitral valve prolapse	π Thyroid disease or malfunction
π Blood disease	π Heart problems	π Nervous problems	
π Cancer	Describe_____________	π Pacemaker/Heart surgery	π Tobacco habit
π Chemical dependency	____________________	π Psychiatric care	π Tonsillitis
π Chemotherapy	π Hemophilia/Abnormal bleeding	π Rapid weight gain or loss	π Tuberculosis
π Circulatory problems		π Radiation treatment	π Ulcer/Colitis
π Cortisone Treatments	π Herpes	π Respiratory disease	π Venereal disease

List medications you are currently taking, if any: ____
List drug allergies, if any:______________________ ____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____Date______________

Payment is due in full at time of treatment, unless prior arrangements have been approved.