

Alpine Dental Center

8585 Huron St.
Denver, CO 80260
(303) 428-6367

Today's Date: _____

Welcome to our office!

Please print and fill out the information on these forms and bring them to your initial visit to our office.

1

About You:

Email: _____

Name: _____

I prefer to be called: _____

Birthdate: ____/____/____ Age: _____

SS# _____

Home Address: _____

City: _____ State: _____ Zip: _____

Circle:

Single Married Divorced Widowed Separated

Male Female

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Occupation: _____ Employer: _____

Work Address: _____

Referred By: _____

Are we seeing other family members? _____

Previous/ Present Dentist: _____

Most recent visit to the dentist? _____

2

Spouse Information:

His/ Her Name: _____

Employer: _____

Work Phone: _____

SS#: _____

Person Responsible for Account: _____

Phone: _____

Billing Address: _____

Relationship: _____ Birthday: ____/____/____

SS#: _____

Employer: _____

3

Insurance:

Primary Insurance:

Dental coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Phone: _____

Insurance Co. Address: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____

Relationship: _____ Birthday: ____/____/____

ID# _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance:

Dental coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Phone: _____

Insurance Co. Address: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____

Relationship: _____ Birthday: ____/____/____

ID# _____

Insured's Employer: _____

Employer's Address: _____

4

Payment:

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

If this office accepts insurance, I understand I am fully responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group[insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnoses and records of treatment or examination rendered, to my insurance company.

Signature: _____ Date: _____

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

5

Medical History

Circle:

Your current physical health is: good fair poor

Do you smoke or use tobacco in any other form? Yes No
 Have you had any metal rods, pins or implants? Yes No
 Have you ever taken Phen-Fen (also known as Redux or Pondimin)? Yes No
 Have you ever taken bone loss prevention drugs? (such as Fosamax or similar) Yes No
 Are you taking any prescription, over the counter or herbal drugs? Yes No

Please List Below:

Medication	Dosage	Frequency

For Women:

Are you using a prescribed method of birth control? Yes No
 Are you pregnant? Yes No Week #
 Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

Yes	No	Medical Condition	Yes	No	Medical Condition
		Abnormal Bleeding			Hepatitis
		Alcohol / Drug Abuse			Herpes / Fever Blisters
		Anemia			HIV+ / Aids
		Arthritis			High / Low Blood Pressure
		Artificial Bones /Joints/Valves			Kidney Problems
		Asthma			Liver Disease
		Blood Transfusion			Lupus
		Cancer/Chemotherapy			Mitral Valve Prolapse
		Colitis			Pacemaker
		Congenital Heart Defect			Psychiatric Problems
		Diabetes			Radiation Treatment
		Difficulty Breathing			Rheumatic Fever / Scarlet
		Emphysema			Seizures
		Epilepsy			Shingles
		Fainting Spells			Sickle Cell Disease / Traits
		Frequent Headaches			Sinus Problems
		Glaucoma			Stroke
		Hay Fever			Thyroid Problems
		Heart Attack			Tuberculosis (TB)
		Heart Murmur			Ulcers
		Heart Surgery			Venereal Disease
		Hemophilia			

Please list any serious medical conditions that you have had.

Are you allergic to any of the following:

Aspirin Yes No
 Codeine Yes No
 Dental Anesthetics Yes No
 Erythromycin Yes No
 Latex Yes No
 Penicillin Yes No
 Tetracycline Yes No

Please list any other drugs / materials that you are allergic to:

5

Medical History Continued

Do you have a professional physician?

Physician's Name: _____

Phone # _____

Date of last visit? _____

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you require antibiotics before dental treatment? Yes No
 Reason? _____

Type? _____

Dosage? _____

6

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Have you ever had a serious or difficult problem associated with any previous dental work? Yes No

Have you now/ever experienced pain or discomfort in your jaw joint (TMJ/ TMD) Yes No

Do you grind your teeth while awake or asleep? Yes No

Do you ever have tired jaws, especially in the morning? Yes No

Do you snore or have any other sleeping disorders? Yes No

Your current dental health is: good fair poor

Have you ever had gum treatment? Yes No

Do your gums ever bleed or hurt? Yes No

How many times a week do you floss? _____

How many times per day do you brush? _____

Type of bristles? soft medium hard

How long do you use your toothbrush before replacing it? _____

Are any of your teeth sensitive to:

Hot or Cold? Yes No
 Sweets? Yes No
 Biting or Chewing? Yes No

Does food tend to be caught in between your teeth? Yes No
 If yes, where? _____

Have you lost any teeth? Yes No

If yes, why? _____

Are you satisfied with your teeth appearance? Yes No

Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes please describe: _____

Please describe anything else about having dental treatment that you would like us to know: _____

7

I understand that the information that I have given here today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____