ARDAS
Family Dental

PERSONAL INFORMATION

1. ABOUT YOU

Date:

Patient Name:

I prefer to be addressed as:

Home Address:

City, Zip:

Pager/Mobile #

Home # Work # ext:

May we contact you at this work phone? ☐ Yes ☐ No

Email address(es)

(We like to e-mail our patients quarterly about dental health updates, specials and updated tools on our website. Please share your email address – which will be kept confidential.)

If we send a children's email update would that be of interest to your household?

☐ Yes ☐ No

(please check): ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partnered

Date of Birth:

Drivers License #

(note, we cannot take checks from those who do not provide their drivers license #)

Employer:

Occupation:

Other family and household members at Ardas Family Dental:

Whom may we thank for referring you? ☐ Phone Book ☐ Website

☐ Referral from another patient: (name)

☐ Other:

2. SPOUSE/EMERGENCY INFO

Spouse/Partner:

Employer:

Cell#:

Work #: Ext.:

Date of Birth:

In the event of an emergency, is there someone other than a spouse you would like us to contact?

Name:

Relation:

Home #:

Cell #:

Work #: Ext.:

3. FINANCIAL INFO

If other than yourself, please list the person responsible for the account and their information below:

Name:

Social Security #:

Billing Address:

Home #:

Work #: ext.:

Relationship to patient:

Employer Name:

4. INSURANCE INFO

Primary Dental Coverage Insurance Co.:

Phone #:

Group Name:

Group #:

Subscriber #:

Insured's Name:

Date of Birth:

Social Security #:

Secondary Dental Coverage Insurance Co.:

Phone #:

Group Name:

Group #:

Subscriber #:

Insured's Name:

Date of Birth:

Social Security #:

Tertiary Dental Coverage Insurance Co.:

Phone #:

Group Name:

Group #:

Subscriber #:

Insured's Name:

Date of Birth:

Social Security #:

Medical Coverage Insurance Co.:

Phone #:

Group #:

ID #:

I authorize release of any information relating to claims filed by **Ardas Family Dental**.

Signature:

I wish to assign benefits to Ardas Family Dental and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature: Date:

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HEALTH INFORMATION

1. HEALTH HISTORY

Today's Date:

Patient Name:

Patient Date of Birth:

Former Dentist:

Clinic-Location:

Phone #:

Last Visit:

Personal Physician:

Clinic-Location:

Phone #:

Please list any medications you are currently taking (include over the counter medicines):

Medications:	Reasons:

Are you currently taking birth control pills? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

2. ALLERGIES

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Amoxicillin	☐	☐	Codeine	☐	☐	Latex	☐	☐	Penicillin
☐	☐	Anesthetics	☐	☐	Erythromycin	☐	☐	Metals/Jewelry	☐	☐	Sulfa
☐	☐	Aspirin							☐	☐	Tetracycline

Other (explain):

(If yes to any, please describe symptoms)

HEALTH INFORMATION UPDATE

Date	Changes	No Change	Patient Initials	Date	Changes	No Change	Patient Initials

3. CONDITIONS

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

Yes	No	
☐	☐	Alzheimer's/Memory Loss
☐	☐	Anemia
☐	☐	Anorexia/Bulimia
☐	☐	Arthritis
☐	☐	Artificial Joints- Date:_____
☐	☐	Artificial Heart Valves
☐	☐	Asthma/Hay Fever
☐	☐	Blood Transfusions
☐	☐	Cancer/Chemotherapy
☐	☐	Cold Sores/Herpes
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug/Alcohol Abuse
☐	☐	Emphysema
☐	☐	Epilepsy/Seizures/Fainting
☐	☐	Gastrointestinal Disorder
☐	☐	Glaucoma (Narrow Angle)
☐	☐	Headaches (Severe, Frequent)
☐	☐	Hearing Impaired
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia/Abnormal Bleeding
☐	☐	Hepatitis A B C D
☐	☐	High/Low Blood Pressure
☐	☐	HIV/AIDS
☐	☐	Liver Disease
☐	☐	Kidney Problems
☐	☐	Migraines
☐	☐	Mitral Valve Prolapse
☐	☐	Pacemaker
☐	☐	Radiation Treatments
☐	☐	Rheumatic/Scarlet Fever
☐	☐	Shingles
☐	☐	Smoking/Tobacco:_____
☐	☐	Sinus Problems
☐	☐	Stints Placed in Heart- Date:_____
☐	☐	Stroke
☐	☐	Snoring/Sleep Apnea
☐	☐	Tuberculosis
☐	☐	Tumor Growth
☐	☐	Venereal Disease
☐	☐	Other/Surgeries

Have you ever been told you need antibiotics before a dentist appointment? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you currently nursing? ☐ Yes ☐ No

Would you like to speak privately with the Doctor about any problems?

☐ Yes ☐ No

I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment is due in full at the time of treatment unless prior arrangements have been approved. Furthermore I understand that a 24 hour notice is required to change appointments.

Signature

Date

Ardas Family Dental, *10233 S Parker Rd, Suite 205, Parker, CO 80134*

720.459.8420

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DENTAL INFORMATION

1. MEETING PATIENT'S IMMEDIATE NEEDS

Patient Name: _____

What brings you here today? ☐ Check-up Time ☐ Problem ☐ Other (explain): _____

Why are you changing dental offices? ☐ Insurance ☐ Location ☐ Didn't Like

☐ Other (explain): _____

Do you have problems with your teeth now? ☐ Yes ☐ No

If Yes (check): ☐ Hot ☐ Cold ☐ Sweet ☐ Food-Caught ☐ Broken Tooth ☐ Other

2. PAST DENTAL HISTORY

When was the last time you saw a dentist? ☐ 1st visit ☐ 6 mo. ☐ 1 yr. ☐ 2 yrs. ☐ 3+ yrs.

What treatment did you receive? ☐ Preventive ☐ Basic Fillings ☐ Major Restoration

Was that a comfortable experience? ☐ Yes ☐ No

Why? _____

Did you have any treatment that was recommended but not yet completed? ☐ Yes ☐ No

If yes: _____

3. HOME CARE & PERIO HISTORY

What do you do at home to take care of your oral health?

☐ Brush; How often: _____ ☐ Floss; How often: _____ Mouthwash: ☐ Yes ☐ No

Any bleeding when you brush or floss your teeth? ☐ Yes ☐ No

Concerned about (check) ☐ Bad Breath ☐ Taste

☐ Other (explain): _____

4. COSMETIC

Are you happy with your smile? ☐ Yes ☐ No

Anything you would like to change if you could? ☐ Color ☐ Shape ☐ Position

☐ Detail (if needed) _____

5. FEARS OR ANXIETIES

Is there anything you don't like about dental appointments?

☐ Discomfort ☐ Fee ☐ Time Inconvenience ☐ Afraid ☐ Other (explain): _____

6. LIFETIME SMILE PLAN

The way we practice dentistry is something we call "Lifetime Smile Plan." What that means is that we provide you with enough education about the health of your mouth so that you can make choices for yourself. This allows you to save your teeth for the rest of your life, while being happy about the way they LOOK and FEEL.

We are going to teach you about what is HEALTHY and UNHEALTHY, and we will provide you with the alternatives to treating the unhealthy areas. We will inform you of the risks, advantages and disadvantages of treating or not treating your teeth as well. One of the alternatives will always be "TO DO NOTHING." We will always inform you of your costs and what you can expect from your insurance before you schedule your treatment, so there will never be any surprise.

Other Comments: _____