PATIENT INFORMATION

DATE _____

NAME _____ Married Single Minor Male Female

Last First M

SOCIAL SECURITY # _____

ADDRESS _____

Street Apt # City State Zip

BIRTHDATE _____ TELEPHONE _____

Month Day Year Cell Home Work

EMAIL _____

NAME OF EMPLOYER _____ ADDRESS _____

PERSON RESPONSIBLE FOR ACCOUNT Patient Guardian Spouse Father Mother

INSURANCE INFORMATION

Minor child may need to complete both blocks for parent info; ADULTS complete primary insured; DUAL COVERAGE complete secondary insured

PRIMARY INSURED ... If no insurance, complete for responsible party	SECONDARY INSURED
Last First M	Last First M
Street City State Zip	Street City State Zip
Cell Home Work E-mail	Cell Home Work E-mail
Birthdate (Month/day/year) Relationship to Patient	Birthdate (Month/day/year) Relationship to Patient
Employer Dental Insurance Company	Employer Dental Insurance Company
Social Security # Subscriber # Group #	Social Security # Subscriber # Group #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/Zip _____

Telephone # _____

Has any member of your family ever been treated in our office?

Yes No

Whom may we thank for referring you to our office?

_____

Authorization

I give permission to release information verbal or written to:

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

ALL IN ONE DENTAL ... 2720 Commercial Way, Montrose, CO 81401 ...Phone: 970/249-4301

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: _____ Examination _____ Emergency _____ Consultation

Dental History

	Please Circle	
Do you have a specific dental problem? If yes, describe _____		
Do you have dental examinations on a routine basis? Date of last visit (if known) _____	Yes	No
Do you think you have active decay or gum disease? _____	Yes	No
Do you brush and floss on a routine basis? _____	Yes	No
Do you like your smile? _____	Yes	No
Does food catch between your teeth? _____	Yes	No
Do you have any loose teeth? _____	Yes	No
Do you want to keep your remaining teeth? _____	Yes	No
Do you ever have clicking, popping, or discomfort in the jaw joint? _____	Yes	No
Do you grind your teeth? _____	Yes	No
Do you smoke or chew? _____	Yes	No
Do you have any sores or growths in your mouth? If yes, discuss _____	Yes	No
Name of previous dentist (optional) _____	Yes	No
Date of last full mouth x-rays (16 small films or panoramic) _____		

Medical History

Are you under a physician's care now? If yes, why? _____		
Who is your physician? _____ Phone # _____	Yes	No
Have you ever been hospitalized or had a major operation? Discuss _____	Yes	No
Have you ever had a serious injury to your head or neck? Discuss _____	Yes	No
Are you on a special diet? Discuss _____	Yes	No
Are you taking and medications, aspirin, vitamins, herbals, pills or drugs? What? _____	Yes	No
Do you need any premedication? _____	Yes	No
Are you taking any blood thinners? _____	Yes	No
Are you allergic to any medications or substances? If yes, please check item below:	Yes	No

_____ Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metal _____ Milk _____ Other

Women: (please check) _____ Pregnant/trying to get pregnant _____ Nursing _____ Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check appropriate Answer. If you answer "yes" to any of the conditions, please call prior to your appointment as premedication or changes in medication may be required.

	YES	NO
Allergies (Medicines)		
Allergies (Pollen/Dust)		
Alzheimer's Disease		
Anemia		
Angina/Chest Pain		
Artificial Joint*		
Asthma		
Arthritis/Gout		
Bacterial Endocarditis*		
Bisphosphonates		
Aredia I.V. Reclast I.V.		
Fosomax, Actonel, Boniva		
Osteonecrosis of Jaw		
Osteoporosis		
Zometa I.V.		
BLOOD THINNERS		

	YES	NO
Bruise Easily/Blood Disease		
Cancer		
X-ray Treatment (Radiation)		
Chemotherapy		
Cold Sores/Herpes		
Congenital Heart Disorder		
Diabetes		
Drug Addiction/Alcoholism		
Emphysema		
Epilepsy or Seizure		
Excessive Bleeding		
Fainting or Dizziness		
Frequent Cough		
Glaucoma		

	YES	NO
Heart Disease/Surgery		
Artificial Heart Valve*		
Coronary Stent*		
Heart Attack/Failure		
Heart Murmur or Defect*		
Heart Pace Maker*		
High Blood Pressure		
Irregular Heart Beat		
Low Blood Pressure		
Mitral Valve Prolapse*		
Rheumatic Fever*		
Scarlet Fever		
Hemophilia		
Hives or Rash		

	YES	NO
Hypoglycemia		
Kidney Problems		
Liver Disease		
Yellow Jaundice		
Lung Disease		
Breathing Problems		
Pulmonary Shunt		
Shortness of Breath		
Nervousness		
Pain in Jaw Joints		
Parathyroid Disease		
Psychiatric Care		
Renal Dialysis		
Rheumatism		

	YES	NO
Sexually Transmitted Disease		
AIDS		
Genital Herpes		
Hepatitis A (infection)		
Hepatitis B or C		
HIV Positive		
Sickle Cell Disease		
Sinus Trouble		
Sleep Apnea		
Stomach/Intestinal Disease		
Stroke		
Swelling of Limbs		
Thyroid Disease		
Tuberculosis		
Tumors or Growths		
Ulcers		

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

Patient Signature (Parent or guardian)

Reviewed by Doctor _____ Date _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions	No change	Patient's Signature	Reviewed by Dentist :
_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	Dr. _____

ALL-IN-ONE DENTAL

Providing ALL your DENTAL needs and wants under ONE roof!

Date _____

I, _____understand I am responsible for payment on the day of service. Any payment arrangements will need to be made prior to the visit with the billing department.
_____Initials

Acknowledgment of Insurance Information

All In One Dental is not contracted with any insurance company or plans. I am aware that the staff of All in One Dental will submit all insurance claims to my dental insurance. I understand that I am responsible for all services that I will have done. I also understand that I am responsible for any or all unpaid services not covered by my dental insurance; I understand that my estimated portion is due at time of service. I may receive a bill if insurance does not pay what was estimated, and I will receive a refund if insurance overpays. _____Initials
I am responsible for the remaining balance if insurance does not pay on my claims for my dental services after 90 days. _____ Initials

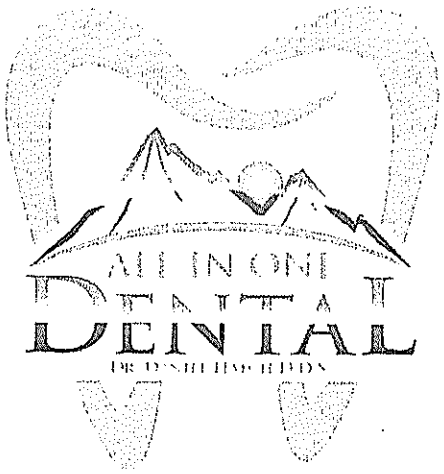
24 hour Cancellation Policy

I am aware a $45.00 charge for cancelling my appointment without 24 hours notice
_____Initials (This fee is not covered by insurance)
I am aware of billable charge of $45.00 per missed appointment
_____Initials (This fee is not covered by Insurance)

Warranty work

I understand that to maintain a warranty on work done by All In One Dental, I am required to continue as a patient at All In One Dental and complete cleanings twice per year (denture patients once per year), a yearly exam with x- rays, good oral home care that includes brushing and flossing daily.Warranty is voided if device or procedure is modified and or altered by myself or any other provider. If there are concerns with your appliance or procedure in order for the warranty to remain in effect you must come in and have the concern evaluated, allowing us the opportunity to repair, remake or refund cost at our discretion.
_____ Initials

Fillings: 2 yrs Crowns: 5 yrs Dentures: Economy 1 yr Premium 5 yrs Implants: 10 yrs



2720 Commercial Way Montrose CO 81401

Phone 970-249-4301

Fax 970-240-8340

Email: info@aiodental.com

Patients name _____DOB_____

Address_____Phone_____

Please check if you have the following:

Implants_____ Dentures (how many years?)_____

Full Records (most recent fmx and perio charting) Implant Info (Brand and Size)

_____

Requesting Records From:

Facility Name_____

Phone Number_____

Fax Number_____

Email_____

Patient Signature_____ Date_____