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 understand that if the person inquiring on my dental account or records is not listed they will not be able to receive any information, I give permission to release information verbal or written to:

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Patient Name _____ **Medical History** **Date** _____

Are you under a physician's care now? If yes, why? _____ Yes No

Who is your physician? _____ Phone # _____

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

_____

_____

Are you taking any blood thinners? _____ Yes No

Are you allergic to any medications or substances? If yes, please check item below:

_____ 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

**** DO YOU NEED A PRE-MEDICATION YES / NO ****

Please read carefully and check mark if you have any of these conditions:

__ Allergies (Medicines)	__ BLOOD THINNERS	__Glaucoma	__ Liver Disease	__ Sickle Cell Disease
__ Allergies(dust/pollen)	__ Bruise Easily / Blood Disease	__Heart Disease/ Surgery	__Breathing problems	__ Sinus Trouble
__ Alzheimer's Disease	__ Cancer	__Artificial Heart Valve*	__ Pulmonary Shunt	__ Sleep Apnea
__ Anemia	__ X-ray Treatment (Radiation)	__ Coronary Stent	__ Shortness of Breath	__ Stomach/Intestinal
__ Angina/Chest pain	__ Chemotherapy	___ Heart Attack/ Failure	__ Nervousness	__ Stroke
__ Artificial Joint*	__ Cold Sores/ Herpes	__ Heart Murmur/Defect*	__ Pain in Jaw Joints	__ Swelling of limbs
__ Asthma	__ Congenital Heart Disorder	__ Heart Pacemaker*	__ Parathyroid Disease	__ Thyroid Disease
__ Arthritis/ Gout	___ Diabetes	__ High Blood pressure	__ Psychiatric Care	__ Tuberculosis
__ Bacterial Endocarditis*	__ Drug Addiction/Alcoholism	__ Irregular heart beat	__ Renal Dialysis	Tumors or Growths
__ Bisphosphonates	__ Emphysema	__ Low Blood Pressure	__ Rheumatism	__Ulcers
__ Aredia I.V. Reclast I.V	__ Epilepsy or Seizures	__ Mitral Valve Prolapse*	__ Sexually Transmitted Disease	__Unexplained Fever
__ Fosamax, Actonel, Boniva	__ Excessive Bleeding	__ Rheumatic Fever*	__ AIDS	__ Genital Herpes
__ Osteonecrosis of jaw	__ Fainting or Dizziness	__ Scarlet Fever	___Hepatitis A (infectious)	__ Hepatitis B or C
__ Osteoporosis	__ Zometa I.V.	__ Frequent Cough	___ Hemophilia	__ HIV Positive

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 and confirm that it adequately states past and present conditions. Sign and date below.

Date	Exceptions, NEW TO REPORT	No change	Patient's Signature	Reviewed by:
_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	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 companies 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 canceling 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: 2yrs Crowns : 5 yrs Dentures: Economy -1yr / Premium- 5 yrs Implants:10yrs

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?)_____

Requesting records From:

Facility Name _____

Phone Number _____

Fax Number _____

Email _____

Patient Signature _____Date _____