WELCOME TO OUR OFFICE

ARVADA FAMILY DENTISTRY

Robert M. Eyer, D.D.S.

Date: _____
Birth Date: _____
Social Security #: _____

PATIENT
NAME: _____ Age: _____ Sex: _____ Marital Status: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
E-Mail: _____
Occupation: _____ Employer: _____ Business Phone: _____

Name of closest relative not living with you: _____
Address: _____ Phone: _____
Whom may we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR PAYMENT – PATIENT, PARENT OR SPOUSE

Birth Date: _____
Name: _____ Social Security #: _____
Employer: _____ Employment Address: _____
How long employed? _____ Occupation: _____ Business Phone: _____
Name of dental insurance company: _____ Group #: _____
How will you pay? Cash _____ Check _____ Credit Card _____

MEDICAL HISTORY

Name of family physician: _____ Address: _____
How is your general health? (please circle) Excellent Good Fair Poor
Do you have, or have you ever had, any of the following? (please circle)

Heart Disease	Heart Murmur	Epilepsy	Tumor History	Hepatitis	Asthma, Emphysema
High Blood Pressure	Thyroid Disease	Fainting	Venereal Disease	Radiation Treatment	Allergies
Blood Disorder, Anemia	Diabetes	Psychiatric Treatment	Sinus Trouble	Liver or Kidney Disease	AIDS
Rheumatic Fever	Stroke	Arthritis	Ulcers	Tuberculosis	

Have you ever tested positive for any of the following blood disorders? (Circle) HIV ARC HBV	YES	NO
Are you under the care of a physician now? Explain _____	YES	NO
Do you have any disease, condition, or problem not listed above? (If YES, list) _____	YES	NO
WOMEN: Are you pregnant? (If YES, Delivery Date) _____	YES	NO
Are you allergic or sensitive to penicillin or *any* other drugs or medicine? Explain _____	YES	NO
Do you need antibiotics for dental work? Explain _____	YES	NO
Have you ever been hospitalized and/or had surgery within the last five years? (If YES, please explain) _____	YES	NO
Do you use smokeless tobacco? _____ Do you smoke? _____		
Are you taking medication, drugs or pills? (If YES, list) _____	YES	NO

DENTAL HISTORY

Do you have a specific problem which needs attention now? _____	YES	NO
Have you had regular dental checkups? _____	YES	NO
When was your last dental visit? _____ What was done then? _____		
Do your gums bleed when brushing or flossing? _____	YES	NO
Have you been told you have a gum problem? _____	YES	NO
Have you lost many teeth? (If YES, why?) _____	YES	NO
Do you feel you will eventually lose all your teeth? _____	YES	NO
Are you apprehensive about receiving any dental treatment? _____	YES	NO
Have there been any complications during previous dental treatment? _____	YES	NO

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease, deformity, or treatment of dental emergency. These procedures may include radiographs, models, and intraoral examination. In the case of a dental emergency, I consent to treatment as deemed necessary by the doctor. I give my consent to the use of local anesthetic and relaxants for completing the necessary dental treatment.

I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY FOR THEM IN FULL.

Signed _____ update _____ _____
Patient, parent or legal guardian _____ _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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