

Aristides A. Tsikoudakis, DMD, LLC

Foothills Prosthetic Dentistry

(303) 984-9200

IMPLANT DENTISTRY
CROWN & BRIDGE
PARTIALS & DENTURES

COSMETIC DENTISTRY
ORAL RECONSTRUCTION
MAXILLOFACIAL PROSTHETICS

APPOINTMENT AND INSURANCE INFORMATION

Important Information: PLEASE READ CAREFULLY

INITIAL EXAM APPOINTMENT

Please arrive 10 - 15 minutes prior to your appointment time. Typically, you can expect your first appointment to last 1 ½ to 2 hours. During this time, the doctor and his staff will gather the necessary information to provide you with a thorough treatment plan and cost estimate. Please let us know if you have brought any recent x-rays with you. In most cases, you will be asked to return to the office for a second appointment for the presentation of your treatment options. There is no additional charge for this treatment consultation appointment.

INSURANCE AND FINANCIAL ARRANGEMENTS

We require that you pay for your initial visit at the time this service is rendered, *regardless of your insurance coverage*. It is our office policy to not carry balances. Payment is expected as your treatment is provided. We accept cash, check, money order, Visa, MasterCard, Discover or American Express. Our initial exam fee is \$98.00 - \$215.00. If Dr. Tsikoudakis requires an x-ray(s) to be taken, there will be an additional charge of \$23.00 to \$245.00, depending on the type and number of x-rays taken

We will be happy to prepare and submit any claims to your insurance and; furthermore, we will ask that your insurance pay whatever benefits are applicable directly back to you for reimbursement. If desired, we will pre-authorize your treatment before treatment begins. Please note that some insurance companies may notify you regarding pre-authorization and not our office. Please contact our office when you receive notification.

If you have questions or concerns, please don't hesitate to call our office. April, our Patient Coordinator, and Jeanette, our Practice Manager will be most happy to help you in any way possible.

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Patient Registration *(CONFIDENTIAL)*

Patient Name _____ Birth Date _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Married Single Divorced Widowed

Patient's Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip Code _____

How long employed _____ Full time Part time Patient's Social Security # _____ -- --

Spouse's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Attendance at this School/College Full time Part time

Person to Contact in Case of Emergency _____ Relationship to Patient _____

Address of Contact Person _____ Phone Number _____

Whom May We Thank for Referring You or How Did You Hear About Us? _____

Reason For Your Visit Today? _____

Responsible Party

Name _____ Relationship to Patient _____

Address _____ Home Phone _____

Birth Date _____ Employer _____ Work Phone _____

Dental Insurance Information

Name of Insured Person _____ Relationship to Patient _____

Birth Date _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip Code _____

Do You Have Secondary Dental Insurance? YES NO *If yes, complete the following:*

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip Code _____

OVER PLEASE ↗

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | |
|--|--|
| <p>Yes No</p> <p>1. Are you under medical treatment now?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Are you taking any medication(s) including non-prescription medicine?..... <input type="checkbox"/> <input type="checkbox"/>
(If yes, please fill out separate medication form)</p> <p>4. Do you use tobacco? <input type="checkbox"/> <input type="checkbox"/>
How many packs per day? _____
How many years have you been smoking? _____</p> <p>5. Do you use alcohol? <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Do you use drugs? If yes, what _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Women Only</p> <p>a.) Are you pregnant or think you may be pregnant? <input type="checkbox"/> <input type="checkbox"/>
- If yes, how many weeks? _____</p> <p>b.) Are you nursing? <input type="checkbox"/> <input type="checkbox"/></p> <p>c.) Are you taking birth control pills?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Has your physician requested that you pre-medicate with antibiotics before visiting the dentist?..... <input type="checkbox"/> <input type="checkbox"/>
If yes, for what conditions? _____
What antibiotic are you taking? _____</p> | <p>Yes No</p> <p>9. Are you allergic to or have you had any reactions to the following?</p> <p>Local Anesthetics (e.g. Novocain) <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa Drugs <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates <input type="checkbox"/> <input type="checkbox"/></p> <p>Sedatives <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex <input type="checkbox"/> <input type="checkbox"/></p> <p>Erythromycin <input type="checkbox"/> <input type="checkbox"/></p> <p>Tetracycline <input type="checkbox"/> <input type="checkbox"/></p> <p>Jewelry <input type="checkbox"/> <input type="checkbox"/></p> <p>Metals <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____</p> <p>Other _____</p> <p>Other _____</p> |
|--|--|

What is your height: _____ Weight: _____

10. Do you have now or have you ever had any of the following?

- | | | |
|--|--|---|
| <p>Yes No</p> <p>High Blood Pressure..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Low Blood Pressure <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic Fever..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart Attack..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart Surgery..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina Pectoris..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood Transfusions <input type="checkbox"/> <input type="checkbox"/></p> <p>Alcohol Abuse..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal Bleeding..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer / Chemotherapy <input type="checkbox"/> <input type="checkbox"/></p> <p>Radiation Therapy <input type="checkbox"/> <input type="checkbox"/></p> <p>Sickle Cell Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay Fever <input type="checkbox"/> <input type="checkbox"/></p> <p>Colitis <input type="checkbox"/> <input type="checkbox"/></p> <p>Psychiatric Problems <input type="checkbox"/> <input type="checkbox"/></p> | <p>Yes No</p> <p>Asthma..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Breathing..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Artificial Bones..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Allergies <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV Infection..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis - <i>circle</i> type A or B .. <input type="checkbox"/> <input type="checkbox"/></p> <p>Kidney Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Liver Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement /Implant..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital Heart Defect <input type="checkbox"/> <input type="checkbox"/></p> <p>Mitral Valve Prolapse..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Artificial Heart Valve..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Pneumocystis Pneumonia <input type="checkbox"/> <input type="checkbox"/></p> <p>Hemophilia <input type="checkbox"/> <input type="checkbox"/></p> <p>Shingles <input type="checkbox"/> <input type="checkbox"/></p> | <p>Yes No</p> <p>Drug Abuse..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy / Convulsions <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting Spells <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Cosmetic Surgery <input type="checkbox"/> <input type="checkbox"/></p> <p>Seizures..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers / Stomach problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Glaucoma <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Venereal Disease..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Fever Blister..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Yellow Jaundice..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Other: _____</p> <p>_____</p> <p>_____</p> |
|--|--|---|

Patient Dental History

- | | |
|--|--|
| <p>Yes No</p> <p>1. Do your gums bleed while brushing or flossing?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Do you feel pain in or around any of your teeth? <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Do you have any sores or lumps in or near your mouth?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Have you had any head, neck, or jaw injuries?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Have you had any orthodontic work? <input type="checkbox"/> <input type="checkbox"/></p> | <p>Yes No</p> <p>8. Have you ever experienced any of the following problems in your jaw:</p> <p>a.) Clicking?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b.) Pain (joint, ear, side of face)?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>c.) Difficulty in opening or closing?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>d.) Difficulty in chewing? <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Do you have frequent headaches?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Do you clench or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/></p> |
|--|--|

Name of General Dentist _____ Date of Last Visit _____

When was your last cleaning? _____ When were your last full mouth x-rays taken? _____

Do you wear removable dentures?..... Yes No If yes please check appropriate box(es) below:

Upper: Partial Full How Long? _____ yrs **Lower:** Partial Full How Long? _____ yrs

For Office Use Only

Health History Reviewed With Patient? Yes No Date: _____ Blood Pressure _____

PERSONAL DENTAL NEEDS SURVEY

At Foothills Prosthetic Dentistry, we utilize today's advanced techniques and materials to literally redesign your smile. Please take a few minutes to fill out the form below to assist us in fully addressing all of your desires and concerns. Even a subtle change in your smile helps you to project an image of self-confidence and high self-esteem!

1. Please rate in order of importance, your primary concerns regarding your dental care.
(The most important would be #1)

_____ Preventative Dental Health Care _____ Cost and Affordability
_____ Excellence and Quality of Service _____ Other _____

2. Please rate, as in Question #1, what a dentist has to do to gain your confidence.

_____ Show me what he is doing or needs to do so I can clearly understand what is happening.
_____ Listen to my concerns and explain thoroughly the procedures to be performed.
_____ Make sure I feel comfortable and informed at all times.

3. Please circle the level of fear you have about your dental visits. (10 being the greatest fear.)

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

4. I would like to know about these options available to me for maximizing my comfort during my visit:

_____ Music and earphones _____ Sedative Medication
_____ Nitrous Oxide _____ Extensive Sedation

Designing Your Dental Health Goals

1. How often do you:

A. Have your teeth professionally cleaned? _____
B. Have routine dental examinations? _____
C. Floss your teeth? _____
D. Have an oral cancer exam? _____

2. How often do you think you should:

A. Have your teeth professionally cleaned? _____
B. Have routine dental examinations? _____
C. Floss your teeth? _____
D. Have an oral cancer exam? _____

3. Do you have:

A. Any missing teeth? _____
B. Untreated dental disease? _____
C. Problems with bad breath? _____
D. An attractive smile? _____

4. Are you concerned about:

A. Replacing missing teeth? _____
B. Recurring or untreated dental disease? _____
C. Pyorrhea or gum disease? _____
D. Mouth odor? _____
E. The appearance of your smile? _____

5. In the past have you: *(Please rate on a scale of 1-10, 10 being the best)*

- A. ____ Had a good experience with dentistry?
- B. ____ Been given good home care instructions?
- C. ____ Made a commitment to your oral health?
- D. ____ Been happy with the appearance of your smile?
- E. ____ Been pleased with the quality of care delivered?

6. Given my past experience, I expect to keep my natural teeth until _____.

7. In the future, I am interested in: *(On a scale of 1-10, 10 being the most interested)*

A. An exceptional dental office experience

1 2 3 4 5 6 7 8 9 10

B. Ideal dentistry – complete and comprehensive

1 2 3 4 5 6 7 8 9 10

C. High quality dentistry – durable and long-lasting

1 2 3 4 5 6 7 8 9 10

D. Low-cost, patch-work dentistry

1 2 3 4 5 6 7 8 9 10

E. Disease prevention program

1 2 3 4 5 6 7 8 9 10

8. Ideally, I would like to keep my natural teeth until_____

9. How would you describe the possibilities of keeping your teeth and gums healthy for a lifetime?

1 2 3 4 5 6 7 8 9 10

10. Is there anything else that you think we should know about your care and treatment in our office?

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Authorization and Release

I certify that I have read and understand the information requested of me on the "Patient Information Sheet" to the best of my knowledge. The medical and dental questions on the Health History form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me (or my child, if applicable) during the period of such dental care to third party payors and/or health practitioners. I DO NOT AUTHORIZE or request that my insurance company pay Dr. Tsikoudakis directly. I request that insurance payments be made directly to me. I understand that my insurance carrier may pay less than the actual bill for services. I further understand that payment in full is due as treatment is rendered (unless prior arrangements have been made with Dr. Tsikoudakis' staff). I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature or Parent, if minor

Date

Patient Name (Please PRINT)