BOULDER PERIODONTICS
SPECIALISTS IN PERIODONTOLOGY
Implants • Oral Medicine

Patient Information

First and Last Name: _____ Date of Birth: _____
Mailing Address: _____ City: _____
State: _____ Zip: _____ SSN#: _____ Email: _____
Cell Phone: _____ Home Phone: _____ Sex: □M □F □X
Emergency Contact and Relationship to Patient: _____ Phone: _____
Referring Dentist Name: _____ Medical Doctor Name: _____
Preferred Pharmacy Name and Location: _____

Dental Insurance

Dental Insurance Company: _____
Claims Mailing Address for Insurance: _____
Name of Policy Holder: _____ Policy Holder DOB: _____
Policy Holder Relation to Patient: _____ Policy Holder SSN: _____
ID #: _____ Group #: _____ Employer: _____

Cancelation Policy

We kindly request 48 hours' notice for the rescheduling of a cleaning appointment, and 72 hours' notice for the rescheduling of a surgical procedure. There may be a charge of up to the total cost of a visit for a missed or cancelled appointment within this time frame. We kindly remind you that it is your responsibility to know the date of your appointment regardless of our automated reminder system. INITIAL: _____

Financial Policies

We are an **OUT OF NETWORK PROVIDER**. Payment is due at the time the services are rendered. We submit all claims on your behalf, as well as treatment plans from the doctors for pre-determination. Please note, we file insurance as a courtesy to our patients, but it is the patient's responsibility to know insurance coverage. We submit to dental insurance only. We are a not a medical office and therefore do not submit to medical insurance, or Medicaid/Medicare. We do not routinely call your insurance company as they may not be able to disclose your personal information to us. INTIAL: _____

We accept Visa, MasterCard, Discover, CareCredit, Checks, and Cash

HIPAA

Notice of Privacy Practices Acknowledgement

By signing below, you are acknowledging the office HIPAA Policies, which are presented on the front office counter.

FOR OFFICE USE ONLY:
We attempted to obtain an acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:
- Individual refused to sign
- Communication barriers prohibited signature
- Emergency situation prevented acknowledgement
- Other

By signing below, I agree to the terms and conditions stated above and will assume full responsibility for all changes incurred at Boulder Periodontics.

Patient Name: _____ Date: _____
Patient Signature: _____

Boulder Periodontics Medical History

Name:_____ DOB:_____ Phone Number:_____

Are you allergic to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □Local Anesthetics Iodine/Shellfish
□ Other:_____

ARE YOU:

Currently under a physician's care?..... □
Specify: _____
A smoker or tobacco user? ..... □
Specify: _____
On a special diet?……..... □
Specify: _____
Taking any Phen-Fen or Redux? …..…..□
WOMEN: Pregnant or Nursing?..... □
WOMEN: Taking oral contraceptives?.... □

IN THE LAST 5 YEARS HAVE YOU:

Been hospitalized? ……..…… □
Specify:_____
Had a major operation ……..... □
Specify:_____
Have you had a recent Vitamin D level? Y/N
Level _____ng/ml <10ng/ml Y/N

HAVE YOU EVER TAKEN:

Bisphosphonates for bone density:
Prolia/Fosamax/Actonel/Reclast, etc…
(Please Circle Any That Apply)
Premedications for dental visits?_____

DO YOU TAKE:

Aspirin _____ Fish Oil _____
Blood Thinners _____
Reclast/Prolia/Fosamax/Actonel
(Please Circle Any That Apply)
Ginseng, Garlic, Ginkgo, or Valerian?
(Please Circle Any That Apply)
CBD Oil or similar products? _____
Vitamin D? _____
Premedications for dental visits? _____

MEDICAL HISTORY:

Anemia……..…… □
Arthritis ……..…… □
Specify: _____
Artificial Heart Valve…….. □
Artificial Joint: ……..……□
Right/Left: _____
Asthma ……..……□
Blood Disorder…….. … □
Bruise Easily……..……..□
Chest Pains……..…… □
Cold Sores……..…… □
Cancer…… □
Specify:_____
Chemotherapy……....□
Radiation Treatments.….□
Congenital Heart Disorder...□
Diabetes:……..…… □
Specify: I, II, or III
Drug Addiction……..…… □
Emphysema……..... □
Epilepsy/Seizures……..… □
Frequent Headaches…..... □
Glaucoma…….. □
GERD……..…… □
Gout ……..…….. .□
HIV Positive……..... .□
Heart Attack/Failure…..… ..□
Heart Murmur…….. ...□
Heart Pace Maker……..…. □
Heart Disease……..……□
Hemophilia……..…..…..…□
Hepatitis: ……...□
Specify: A, B, or C
High Blood Pressure…..……□
Hypoglycemia……..……□
Digestive Disease……□
Specify:_____
Irregular Heart Beat…….……□
Specify: _____
Jaw Joint Clicking or Pain…...□
History of TMJD Treatment….□
Kidney Problems…… □
Leukemia……..…□
Liver Disease……..…..…..…□
Low Blood Pressure……..…..□
Mitral Valve Prolapse……..□
Osteoporosis……..…..□
Osteopenia……...□
Parathyroid Disease……□
Psychiatric Care……...□
Recent Weight Gain/Loss……□
Shingles……..□
Sinus trouble……..□
Stroke……..□
Thyroid Disease……...□
Tuberculosis……..□
Ulcers……..……□

Any other illness/syndrome not listed above?

_____
_____
_____

PLEASE LIST ALL MEDICATIONS YOU TAKE:
(including over the counter, herbal, or minerals)

_____
_____
_____
_____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications you may be taking have an important interrelationship with the dentistry you will receive. I understand that providing incorrect information can be dangerous to my (or patient's) health. Thank you for answering these questions!

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ **DATE**_____
Reviewed by Dr._____