ROCKY MOUNTAIN
DENTAL SPECIALISTS

1551 Professional Lane, Suite 250
Longmont, CO 80501
(720) 597-3344

Registration Form

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____

Home _____ Office _____ Mobile _____

E-mail _____

Preferred method of communication? _____

Gender: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed

Referring Doctor's Name? _____

Preferred Pharmacy Name and Locations: _____

Date of Birth ☐☐☐☐ Patient SSN ☐☐☐-☐☐-☐☐☐☐

Emergency Contact _____

Relationship to Patient _____ Phone _____

Dental Insurance

Patient Name _____

Policy Holder's Name _____

Relationship to Patient _____

Policy Holder's Date of Birth ☐☐☐☐ Policy Holder's SSN ☐☐☐-☐☐-☐☐☐☐

Policy Holder's Employer _____

Dental Insurance Company _____

Dental Insurance Address: _____

City _____ State _____ Zip _____

Policy Holder's Identification Number _____ Group Number _____

We are OUT OF NETWORK with your dental insurance company so please confirm that you are free to see the provider of your choice. Payment is expected at the time the services are rendered. Evaluations are to be paid in full at time of service. You are responsible for knowing your insurance coverage and limitations of your plan (such as yearly maximums and deductibles). We are not a medical office and therefore do not submit to medical insurance. Please be aware, we are not a Medicare/Medicaid provider.

HIPPA

Notice of Privacy Practices Acknowledgement

By signing below, you are acknowledging office HIPPA policies, a copy is available upon request.

Signature: _____ Date _____

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Written Financial Policy

Thank you for choosing RMDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. **Payment for treatment is due at the time of service.**

Payment Options:

- **Consultations, Examinations and Cleanings:** Payment is due at the time services are rendered.
- **Surgeries, Procedures, Scaling and Root Planning:** One half of the payment is due at the time of service. The remainder of the balance is due within 90 days of services rendered.
- **Prosthetic Services:** We require half of the treatment plan amount at the start of treatment and the balance to be paid over the remaining appointments. We require full payment prior to the completion of your case. Extensive treatment may require special payment arrangements, and we will work alongside you to establish arrangements for you at the treatment planning conference.

- **We accept the following forms of payment:**
  - -Credit & Debit Cards: Visa, Mastercard, Discover, HSA cards
  - -Cash or Check
  - -Care Credit is our medical/dental third-party financing option. We offer a promotional period of 6 months deferred interest; transactions must be over $200. You may apply for an account online at www.carecredit.com. Surgeries must be paid in full if using.

- **Billing:** We send out monthly bills to all accounts with balances. If the balance is not paid within 90 days of services rendered a 18% finance charge per month will be added any unpaid balance until paid in full. RMDS charges $40 for returned checks.

Patients with Dental Insurance

RMDS is a non-participating provider and out of network with all dental insurances. Following treatment RMDS will submit all claims to the proper dental insurance companies, in turn the patient will receive payment/ reimbursement for services directly from their insurance provider. RMDS is not responsible for pretreatment authorization and estimates. We do our best to communicate with you how to best utilize your plan to obtain maximum benefits, we are here to help you receive the best quality of care.

Cancellation Policy - We kindly ask for a 72-hour cancellation notice for all appointments. A charge may be applied to your account for an appointment that is missed or not rescheduled within this timeframe.

The undersigned agrees that if this account is not paid when due, and RMDS should retain an attorney or collection agency for collection, the undersigned agrees to pay all costs of collection including court costs, reasonable interest, reasonable attorney's fees and reasonable collection agency fees.

If you have any questions, please do not hesitate to ask. We are here to help you get the smile you want.

_____ _____

Patient, Parent or Guardian

Date

*Subject to credit approval
**All payments are due upfront at time of service, your insurance carrier will distribute payment directly to you.

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Dental History

Name _____ Date of Birth ____ ____ ____ Age ____

Dentist _____ Office Phone _____

Specialty Dentist _____ Office Phone _____

Why are you seeking dental treatment? _____

_____

_____

Have you ever had any serious trouble associated with previous dental treatment? _____

_____

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Date of your last dental visit? _____ Date of your last dental cleaning? _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

Do you have or have you ever had any of the following?

	YES	NO		YES	NO
Bleeding, sore gums	☐	☐	Loose Teeth	☐	☐
Unpleasant taste/bad breath	☐	☐	Sensitive to hot	☐	☐
Frequent blisters, lips/mouth	☐	☐	Sensitive to cold	☐	☐
Burning tongue/lips	☐	☐	Sensitive to sweets	☐	☐
Swelling/lumps in mouth	☐	☐	Sensitive to biting	☐	☐
Orthodontics (braces)	☐	☐	Food impaction	☐	☐
Biting cheeks/lips	☐	☐	Clenching/grinding	☐	☐
Clicking/popping jaw	☐	☐	Shifting of Teeth	☐	☐
Difficulty opening or closing jaw	☐	☐	Change in bite	☐	☐

Do you use any of the following?

	YES	NO	
Tobacco, in any form?	☐	☐	If so, how much? _____
Alcohol?	☐	☐	If so, how much? _____
Recreational drugs?	☐	☐	If so, how much? _____

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Medical History

Name: _____ DOB:_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Iodine/Shellfish
☐ Other:_____

For the following sections, please only check any that apply

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 FIVE YEARS HAVE YOU:

Been hospitalized? ..... ☐
Specify: _____
Had a major operation ..... ☐
Specify: _____

HAVE YOU TAKEN IN THE LAST FIVE YEARS:

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

ANY OTHER MEDICATIONS YOU TAKE / HAVE TAKEN RECENTLY:
(including over the counter, herbal, or minerals)

_____
_____
_____

DO YOU HAVE OR HAVE YOU EVER HAD:

Alzheimer's Disease..... ☐
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..... ☐
Easily Winded..... ☐
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..... ☐
Irregular Heart Beat..... ☐
Specify: _____
Jaw Joint Clicking..... ☐
Jaw Joint Pain..... ☐
History of TMJD Treatment..... ☐
Kidney Problems..... ☐
Leukemia..... ☐
Liver Disease..... ☐
Low Blood Pressure..... ☐
Mitral Valve Prolapse..... ☐
Night Sweats..... ☐
Osteoporosis..... ☐
Osteopenia..... ☐
Pacemaker..... ☐
Parathyroid Disease..... ☐
Psychiatric Care..... ☐
Radiation Therapy..... ☐
Recent Weight Gain/Loss..... ☐
Shingles..... ☐
Sinus trouble..... ☐
Intestinal Disease..... ☐
Specify: _____
Stroke..... ☐
Thyroid Disease..... ☐
Tuberculosis..... ☐
Ulcers..... ☐
Any other serious illness not listed above?
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE**_____

REVIEWED BY _____

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