ROCKY MOUNTAIN
SMILES

PAUL R. BIGUS, D.D.S.
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970-667-1293

Date:_____

Patient's Name:_____ Gender □ Male □ Female

Address:_____ City, State, Zip:_____

Birthdate:_____ Social Security #_____

Home #_____ Cell #_____ Email:_____

Employer: _____ Emergency Contact Name/Number:_____

Who may we thank for referring you to our office?_____

Responsible Party Information (if someone other than patient)

Name:_____ Birthdate:_____ Spouse:_____

Employer:_____ Occupation:_____

Address:_____ City, State, Zip:_____

Social Security #_____ Home #_____ Cell #_____

We ask that you please notify us at least 48 hours in advance if needing to change or cancel any appointments

Insurance Information

Name of Primary Insured:_____ Relationship to Patient □ Self □ Spouse □ Child □ Other

Insured SS# or Insurance ID#_____ Insured Birthdate:_____

Name of Insurance Co:_____ Insurance Phone #_____ Employer:_____

Secondary Ins Subscriber:_____ Relationship to Patient □ Self □ Spouse □ Child □ Other

Insured SS# or Insurance ID#_____ Insured Birthdate:_____

Name of Insurance Co:_____ Insurance Phone #_____ Employer:_____

Patient Name:_____

Physician's Name:_____ Phone #:_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Sulfa □ Local Anesthetics □ Metal

Are you taking any medications, pills or drugs? □ Yes □ No If yes, please list: _____

_____

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

□ AIDS/HIV Positive
□ Alzheimer's/Dementia
□ Anaphylaxis
□ Anemia
□ Angina/Chest Pain
□ Arthritis/Gout (circle)
□ Artificial Heart Valve
□ Artificial Joint
□ Asthma
□ Bleeding Disorders
□ Blood Disease
□ Blood Transfusion
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Chronic Infection
□ Cold Sores/Fever Blisters
□ Convulsions
□ Diabetes
□ Drug/Alcohol Addiction
□ Emphysema
□ Epilepsy/Seizures
□ Fainting/Dizziness
□ Frequent Cough
□ Glaucoma
□ Hay Fever/Allergies
□ Heart Attack/Failure
□ Heart Murmur
□ Heart Pacemaker
□ Heart Trouble/Disease
□ Hepatitis
□ High Blood Pressure
□ Hives/Rash
□ Hypoglycemia
□ Irregular Heartbeat
□Kidney Problems
□ Leukemia
□ Liver Disease/Jaundice
□ Low Blood Pressure
□ Lung Disease
□ Mitral Valve Prolapse
□ Pain in Jaw
□ Psychiatric Care
□ Radiation
□ Recent Weight Loss
□ Reflux/Heartburn
□ Renal Dialysis
□ Scarlet Fever
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Stomach/Intestine
□ Stroke/TIA (circle)
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Ulcers
□ Venereal Disease

Are you under a physician's care now □ Yes □ No If yes, please explain_____
Have you ever been hospitalized? □ Yes □ No If yes, please explain_____
Have you had major surgery? □ Yes □ No If yes, please explain_____
Have you ever had a serious head/neck injury? □ Yes □ No If yes, please explain_____
Do you use controlled substance? □ Yes □ No If yes, please explain_____
Women: □ Are you Pregnant? □ Trying to get Pregnant? □ Nursing? □ Taking Oral Contraceptives?
Have you ever had a serious illness not listed above? □ Yes □ No If yes, please explain_____
Are you experiencing any problems? □ Yes □ No If yes, please explain _____
When was your last dental visit?_____ Do you gag easily? □Yes □ No Smoke/Chew □ Yes □ No

TREATMENT AUTHORIZATION AND ACKNOWLEDGMENT

I consent to treatment as necessary or desirable for diagnosis of dental disease, deformity, or treatment of a dental emergency. These procedures may include radiographs, models, photographs and intraoral examination. In case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding the procedure will be explained in advanced. I understand it is solely my responsibility to report any changes in the above medical information to this office.

Signed_____ Date_____

Rocky Mountain Smiles
Dr. Paul Bigus

FINANCIAL AND SCHEDULING POLICY

We hope you understand that our financial policies are established to assure the financial resources needed to maintain this dental office for all our patients. We will work with you to ensure that your dental care does not become a financial burden.

~ Charges for dental services are due and payable at the time of service. We accept cash, personal checks, care credit and most major credit cards for payment.

Dental Insurance:

~ Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.

If you have dental insurance with which we participate:

~ We will bill your insurance claim for you

~ We expect any required co-payment at the time of service

Accounts 90 past due are subject to collections proceeding. If you default on payment you will be responsible for ALL costs of collections including but not limited to collection agency fees, attorney fees and court costs.

Scheduling Policy:
Our procedure for confirming appointments will be to contact you electronically via text, email or phone call. If it becomes necessary to alter your appointment, please provide us with a minimum **48 hour** notice to avoid a cancellation fee.

I have read and understand the above. Please sign_____

HIPPA PRIVACY PRACTICE NOTICE

I acknowledge being offered a copy of the HIPPA Privacy Practice Notice.

Sign:_____ Date:_____

I give permission to my private dental information including but not limited to; billing, treatment, associated treatment fees, appointment dates and times to the following individuals...

Name:_____ Relationship:_____