YOUR INFORMATION

Patient's Legal Name _____ Date: _____

Preferred Name _____ Whom may we thank for referring you _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Date of Birth _____ Social Security No. _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Name of Spouse _____

Other family members seen by us _____

Place of Employment _____

Occupation _____ Business Phone _____

Emergency contact _____ Relationship to patient _____

Address _____

Home Phone _____ Cell Phone _____

FINANCIAL RESPONSIBILITY

Person responsible for this account _____

Relationship to patient _____ Date of birth _____

Social Security No. _____ Driver's License No. _____

Address _____

Home Phone _____ Cell Phone _____

Place of Employment _____

Occupation _____ Business Phone _____

INSURANCE INFORMATION

Dental Insurance Company Name _____

Dental Insurance Company Name _____

Group # _____ Policy # _____ ID # _____

Insured Name _____ Relationship _____ Date of birth _____

Employer _____ Business Phone _____

Employer Address _____ Do you have secondary health insurance? Y / N

Reviewed by: **Dr. Dastrup** _____ **Team Member** _____ **Recorded** _____

Patient's Name _____ Date: _____

Name of your physician _____ Physician's Phone _____

Currently under a physician's care ❑ Yes ❑ No Conditions be treated _____

Hospitalized or had a serious illness within the last 5 years ❑ Yes ❑ No If yes, please describe _____

_____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

- ❑ Artificial heart valve
- ❑ History of bacterial endocarditis
- ❑ Cardiomyopathy
- ❑ History of rheumatic heart disease
- ❑ Mitral valve prolapse
- ❑ Congenital heart malformations
- ❑ Artificial joint (placed in the last 2 years)
- ❑ Any foreign objects surgically placed in your body
- ❑ Need a pre-med Medication: _____

YES	NO	
❑	❑	Have you ever been treated for cancer? Type & Date: _____
❑	❑	Have you ever received bisphosphonate drug? (e.g. Aredia, Zometa, Fosamax)
❑	❑	Have you ever taken Fen-Phen (weight loss supplement)?
❑	❑	Do you have thyroid problems? ❑ Hypothyroidism ❑ Hyperthyroidism

CHECK IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

❑ Aspirin ❑ Penicillin / Amoxicillin ❑ Codeine ❑ Latex ❑ Sulfa drugs

❑ Anesthetics (please list) _____

❑ Any other allergies (please list) _____

LIST ANY PRESCRIPTIONS OR OVER THE COUNTER MEDICATIONS/SUPPLEMENTS YOU ARE PRESENTLY TAKING:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

DO YOU HAVE APNEA OR SNORE? ❑ Yes ❑ No Year Diagnosed _____ **DO YOU WEAR A CPAP?** ❑ Yes ❑ No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (check if yes)

- ❑ Abnormal bleeding
- ❑ Acid Reflux
- ❑ Alcohol abuse (current or past)
- ❑ Alzheimer's Disease
- ❑ Asthma
- ❑ ADD / ADHD
- ❑ Chest Pain
- ❑ Cold Sores / Fever Blisters
- ❑ Diabetes
- ❑ Drug abuse (current or past)
- ❑ Eating disorder (anorexia/bulimia)
- ❑ E-cigarettes / Vaping
- ❑ Emphysema
- ❑ Headaches / Migraines
- ❑ Heart Attack
- ❑ Hepatitis A, B or C
- ❑ High Blood Pressure
- ❑ HIV / AIDS
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Low Blood Pressure
- ❑ Organ Transplant
- ❑ Pacemaker
- ❑ Radiation / Cancer Therapy Date: _____
- ❑ Seizures / Epilepsy
- ❑ Sinus Problems
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Tobacco (chew / smoke / marijuana)

WOMEN: CHECK IF YOU ARE CURRENTLY…

❑ Pregnant ❑ Nursing ❑ Using Contraceptives

Updated: Signature _____ **Date** _____

Reviewed by: Dr. Dastrup _____ **Team Member** _____ **Recorded** _____

Patient's Name _____ Date: _____

Approximate date of last dental visit _____ Date of last dental x-rays _____

What do you expect from today's visit? _____

_____

_____

What are some of your goals from your teeth/smile? _____

_____

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (check if yes)

- ❑ Have you been told you stop breathing while you sleep
- ❑ Do you currently wear a dental guard/appliance

Mouth Concerns:

- ❑ Acid Reflux
- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Chew on one side of mouth
- ❑ Clicking or popping jaw
- ❑ Dry mouth
- ❑ Headaches
- ❑ Eating disorder (anorexia/bulimia)
- ❑ Fingernail biting
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Gums swollen or tender
- ❑ Jaw pain
- ❑ Lip or cheek biting
- ❑ Loose teeth/broken fillings
- ❑ Ringing in the ears
- ❑ Mouth breathing
- ❑ Mouth pain while brushing
- ❑ Orthodontic treatment
- ❑ Pain around ear
- ❑ Periodontal treatment
- ❑ Piercing in the mouth
- ❑ Sores/growths in mouth
- ❑ Tooth sensitivity of heat/cold
- ❑ Worn teeth

Jaw Concerns:

- ❑ Jaw aches or jaw muscle stiffness
- ❑ Radiating pain in the face, jaw or neck
- ❑ Limited movement or locking of the jaw
- ❑ Change in the way the upper and lower teeth fit together
- ❑ Painful clicking, popping or grating in the jaw joint when opening or closing the mouth

Updated: Signature _____ **Date** _____

Reviewed by: Dr. Dastrup _____ **Team Member** _____ **Recorded** _____

Jared Dastrup DDS 5725 Erindale Drive • Suite 106 • Colorado Springs CO 80918

Patient's Name _____

I acknowledge that I have been offered/received a copy of the Statement of Privacy Practices for the office of Jared Dastrup, DDS. The statement of Privacy Practices describes the ways in which my protected health information may be used during the course of my treatment or during office duties related to such treatment.

I, _____ am the "personal representative" and have legal authority to make health care decisions on behalf of the above mentioned patient.

MAY WE LEAVE A DETAILED MESSAGE WITH APPOINTMENT TIMES?

❑ YES	❑ NO	**WORK**	Number(s): _____
❑ YES	❑ NO	**HOME**	Number(s): _____
❑ YES	❑ NO	**CELL**	Number(s): _____
❑ YES	❑ NO	**EMAIL**	Address(es): _____
❑ YES	❑ NO	**TEXT**	

I AUTHORIZE THE FOLLOWING INDIVIDUAL(S) TO HAVE ACCESS TO MY HEALTH INFORMATION:

Name(s)	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

RESPONSIBLE PARTY'S SIGNATURE **DATE**

For office use only · Record of Acknowledgement not obtained

____ Patient refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (specify) _____

Reviewed by: **Dr. Dastrup** _____ **Recorded** _____

Jared Dastrup DDS 5725 Erindale Drive • Suite 106 • Colorado Springs CO 80918

Patient's Name _____

HEALTH INFORMATION CERTIFICATION: I hereby certify that the above information regarding the medical/dental history of the above named patient is complete, true, and correct and may be relied upon for all purposes by Jared Dastrup, D.D.S., his assistants, hygienists, team members, and any other persons treating or assisting in the treatment of the patient.

FINANCIAL AGREEMENT: I, as the responsible party agree to the following:

1) Pay the doctor at the time of treatment or when service is rendered unless previous arrangements have been made.
2) Pay a $50.^{00}$ fee for cancellation of appointments without 24 hour notice.
3) Pay a 1.5% monthly finance charge on the unpaid balance (18% annual rate) with a minimum charge of $.50 per month if payments are extended beyond 30 days from the date of the first billing.
4) If my account becomes delinquent, I permit this office to request and report credit profiles from the local credit bureau. If this account is assigned to an outside agency for collection, I/we agree to pay all attorney fees, with or without suit, court costs, and a collection agency fee of 40%, which will be added to the outstanding balance of my account.
5) Pay a $35.^{00}$ returned check fee for any payments returned by my bank due to insufficient funds. 6) I have been offered a copy of the financial policy and agree to abide by it.

INSURANCE RESPONSIBILITY: I understand it is my responsibility to know and understand my insurance plan and the dental coverage available. All quoted insurance co-pays are only an estimate. I accept responsibility for obtaining/requesting any written "pre-authorization" or "prior approval" required by my dental insurance company.

CONSENT TO PROCEED: There are many benefits to you as a patient that come from receiving regular dental treatment. These may include: relief from pain, proper chewing function, enhanced smile, and healthy teeth and gums.

While we certainly advocate receiving regular dental care, there are some inherent risks associated with treatment of any part of the human body, including treatment of your jaws, teeth, and gums. While the risks of dental treatment are seldom great enough to offset the benefits, they should be considered when making treatments decisions.

The following is a list of common risks associated with almost any dental procedure:

1. **Drug and chemical reaction:** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long term numbness (paresthesia):** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient (temporary but lasting longer than intended), or in rare instances, permanent numbness.
3. **Muscle or joint tenderness:** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding**
5. **Swallowing or inhaling small objects**

Please be assured that we have procedural guidelines in place to minimize the possibility of any of the above risks. Please feel free to ask questions about any dental procedure that you are having completed.

In addition, by signing below, you understand that you may be photographed or in rare cases videotaped during your treatment period. X-rays will also be taken as necessary. Photos of your mouth will be used to help demonstrate various oral health conditions present in your mouth. On occasion we may use video for staff training purposes but will likely not show your face. These photos or videos will **only** be used within the office of Dr. Jared Dastrup. Finally, we may ask you to write a personal testimony about your dental visit, so we ask your permission to publish it in marketing materials or quote you on our Facebook page and other social media platforms. **Any other use will be by separate consent.**

I certify that I have read this agreement and by my signature, I agree to the terms set forth above. In the case of submitting an insurance claim, I hereby authorize the release of any information necessary to process it and authorize payment directly to the provider.

_____ _____

RESPONSIBLE PARTY'S SIGNATURE **DATE**

Reviewed by: Dr. Dastrup **Recorded** _____