homestead dental

Andrew J. Schope, D.D.S.
Andrew C. Cote, D.D.S
6990 South Holly Circle, Centennial CO 80112

Welcome To Our Office

Date_____

Patient Information

Patient Name:_____ _____ _____ _____
Last First MI Preferred Name

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Social Security #:_____ Drivers License #:_____ Birth Date: _____

Sex: M F Marital Status: (Please Circle) Single Married Divorced Widowed Separated

Phone Numbers:

Home_____ Work_____ Cell_____

E-Mail Address: _____

Employer Name:_____ Address:_____

_____

Who referred you to our practice: _____

Responsible Party Information

Name:_____ _____ _____ _____
Last First MI Preferred Name

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip Code

Social Security #:_____ Drivers License #:_____ Birth Date: _____

Sex: M F Marital Status: (Please Circle) Single Married Divorced Widowed Separated

Phone Numbers:

Home_____ Work_____ Cell_____

E-Mail Address: _____

Employer Name:_____ Address:_____

_____

Dental Insurance Information

Primary Insured Name:_____ Birth Date:_____

Social Security # or ID #:_____

Employer:_____ Group #:_____

Insurance Company Name:_____ Phone #:_____

Address:_____

_____

* Please notify the front desk if you have secondary dental insurance *

Emergency Information

Emergency Contact

Name:_____

Phone #:_____

Family Physician

Name:_____

Phone #:_____

Patient Name:_____

DENTAL HISTORY

	Yes	No
1 Please state briefly the reason for your visit _____		
2 Do you have any discomfort in your mouth?	◯	◯
3 Have you had any bad experiences in the past?	◯	◯
4 Do you experience anxiety with dental appointments?	◯	◯
5 Would you like your smile to look better or different?	◯	◯
6 Are you happy with the color of your teeth?	◯	◯
7 When was your last dental cleaning? _____		
8 Were x-rays taken at that time?	◯	◯
4 Bitewing x-rays		
Full Mouth Series or Panoramic		
9 Do your gums bleed, feel tender or irritated?	◯	◯
10 Have you ever been numb for a cleaning?	◯	◯
11 Do you floss your teeth? (Please circle)		
Always Sometimes Rarely Never		
12 Do you brush your teeth with? (Please circle)		
Manual toothbrush Electric toothbrush		

	Yes	No
13 Do you have pain or sensitivity to? (Please circle)	◯	◯
Hot Cold Sweets Biting Pressure		
14 Does food wedge between certain teeth?	◯	◯
15 Are any teeth loose?	◯	◯
16 Have you experienced any growths or sore spots in your mouth?	◯	◯
17 Do you grind, clench or grit your teeth?	◯	◯
18 Does your jaw cause you pain?	◯	◯
19 Does your jaw ever click on opening or closing?	◯	◯
20 Do you currently wear a night guard?	◯	◯
21 Has a previous dentist recommended a night guard?	◯	◯
22 Have you ever had any teeth extracted?	◯	◯
23 Have you worn braces?	◯	◯
24 Are you currently wearing a removable dental appliance?	◯	◯
25 Do you wear dentures?	◯	◯
If yes, are you satisfied with your present dentures?	◯	◯

* Have you ever had Botox and/or Dermal-Fill treatment?	Yes ◯	No ◯
* Would you be interested in Botox and/or Dermal-Fill Treatment?	Yes ◯	No ◯
* Do you experience headaches or have head or facial pain?	Yes ◯	No ◯

MEDICAL HISTORY

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 medication you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	Yes	No
1 Are you under any medical treatment now?	◯	◯
If yes, please explain_____		
2 Have you ever been hospitalized or had a major operation?	◯	◯
If yes, please explain_____		
3 Have you had any joint replacements or surgeries including plates and screws?	◯	◯
4 Have you ever been told to premedicate with antibiotics prior to your dental appointments?	◯	◯
5 Are you taking medication, herbs or holistic supplements?	◯	◯
6 Are you taking or have you taken Bisphosphonate medications? (This medication is used to treat Osteoporosis, Hormone Replacement Therapy and various Cancers)	◯	◯
7 Have you ever had kidney dialysis treatment?	◯	◯
8 Have you ever had abnormal bleeding after a cut or tooth extraction?	◯	◯
9 Do you use tobacco products?	◯	◯

Are you allergic to any of the following?

	Yes	No		Yes	No
Aspirin	◯	◯	Metal	◯	◯
Acrylic	◯	◯	Penicillin/Amoxicillin	◯	◯
Latex	◯	◯	Clindamycin/Cleocin	◯	◯
Local Anesthetics	◯	◯			

Other_____

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

	Yes	No		Yes	No
AIDS/HIV Positive	◯	◯	Hepatitis A	◯	◯
Angina	◯	◯	Hepatitis B, C, D or E	◯	◯
Artificial Heart Valve	◯	◯	High Blood Pressure	◯	◯
Artificial Joint	◯	◯	HPV Human Papilloma Virus	◯	◯
Asthma	◯	◯	Liver Disease	◯	◯
Blood Disease	◯	◯	Mitral Valve Prolapse	◯	◯
Breathing Problem	◯	◯	Rheumatic Fever	◯	◯
Diabetes	◯	◯	Scarlet Fever	◯	◯
Epilepsy or Seizures	◯	◯	Stomach/Intestinal Disease	◯	◯
Heart Murmur	◯	◯	Stroke	◯	◯
Heart Trouble/Disease	◯	◯	Tuberculosis	◯	◯
Hemophilia	◯	◯	Tumors or Growths	◯	◯

Women:	Yes	No		Yes	No
Are you pregnant?	◯	◯	Taking oral contraceptives?	◯	◯
Trying to get pregnant?	◯	◯	Nursing?	◯	◯

Please list medications and reasons for taking:

_____

_____

Is there any Medical or Dental information you feel I should know about?

_____

_____

CONSENT: The undersigned hereby authorized Doctor to take x-ray, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself of my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

_____ _____ _____

PATIENT, PARENT OR GUARDIAN DATE DENTIST SIGNATURE

CONSENT TO PROCEED

Homestead Dental

Dr. Andrew J. Schope, D.D.S. and Dr. Andrew C. Cote D. D.S.

I authorize Dr. Andrew Schope, Dr. Andrew Cote, and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare it is also possible for the tongue, cheek or other oral tissue to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____
(Please print legibly)

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

HOMESTEAD DENTAL

Andrew J. Schope, D.D.S.
Andrew C. Cote, D.D.S.

Health Insurance Portability Act
Acknowledgement Form (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Crown Dental to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatments)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time obtain the most current copy of notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

PRINT PATIENT NAME DATE

_____

SIGNATURE OF PATIENT OR GUARDIAN