URGENT DENTAL
OF DENVER

**Today's Date:** _____

**Patient Name:** _____
Last Name First Preferred Name

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Gender:** MALE ◯ FEMALE ◯ **Birth Date:** _____

**Family Status:** MARRIED ◯ SINGLE ◯ CHILD ◯ OTHER ◯

**Phone Number:** _____ **Home** ◯ **Cell** ◯ **Work** ◯

**Phone Number:** _____ **Home** ◯ **Cell** ◯ **Work** ◯

**Social Security #** _____ **Drivers License #** _____

**Email Address:** _____

**Employer:** _____

**Employer's Address:** _____
Phone

How Did you hear about us? Internet, Family or Friend: _____

Other: _____

**Toothache ER Questionnaire:**

What is the Main Concern for your Visit Today?

_____

Are you experiencing throbbing or aching? Please Circle: **Yes or No**

Are you experiencing hot and cold sensitivity? **Yes or No**

Is your tooth pain related to an accident or fall? **Yes or No**

Is your pain on the right or left side? Please circle: **Right or Left**

Upper or lower area? Please Circle: **Upper or Lower**

Have you taken any pain relievers within the last 4 hours? **Yes or No**

On a Scale of 1-10 with 1 being the least painful and 10 being the most painful where would you gage your dental pain today? _____

If Dental treatment can be completed today are you interested in N20 "laughing gas" during your treatment? _____

Please sign the below consent:

I am aware I am being seen today for an Urgent Dental visit and may have a wait to be seen depending on the needs of all Urgent Dental Patients. I understand that the health and wellness of all our patients is the most important thing to our providers. I will be cared for with 110% dedication and I am aware that our providers will do everything they possibly can to see me at my appointment time. Due to the nature of Dental Emergencies I understand my appointment duration can vary. If Urgent Dental is running behind we will do our best to keep you updated. I understand that it is important to be on time for my scheduled appointment so that other patients are not affected. I understand that if I arrive late I run the chance of not being seen for treatment or being seen must later than my scheduled time.

Signature: _____ Date: _____

# Appointment & Financial Policy

Please be aware that charges incurred for treatment provided are your responsibility regardless of any expected insurance coverage. Dental insurance is a benefit used to assist you with the cost of necessary dental expenses and should neither dictate nor prohibit treatment. As we work with you to reach your optimum oral health, **we require estimated out of pocket /copay at time of service**.

As a courtesy to you, we will submit claims to your dental insurance on your behalf. However, it is important that you understand that the agreement regarding your dental insurance and dental benefits is between you, your employer, and your insurance company. Although we are willing to submit dental claims on your behalf, you are financially responsible for the services rendered in our office.We are out of network with most dental insurance but we will be happy to submit your claim for reimbursement of your out of pocket expense today.

Urgent Dental accepts payment in the form of cash, Amex, Discover, MasterCard, Visa and CareCredit. **All treatment over $500 will require a non-refundable $100 deposit which will be used as a no show fee if you no show or same day cancel your treatment appointment.**

We strive to keep all financial arrangements and accounts in house. However, account balances left unpaid for 90 days or more may be sent to a third party collection agency. You are responsible to pay all costs of collections including, but not limited to; collection fees, attorney fees, and interest.

Please keep in mind that we have reserved time in our schedule especially for you. We urge you to keep your appointments, due to limited time and space. **If you need to cancel or reschedule your appointment, please give us at least 48 hours notice**, so that we may offer your reserved time to another patient in need of dental care.

I have read, understand, and accept the terms and conditions of this policy.

| Printed Name of Patient | Signature of Patient | Date |
|---|---|---|

# ACCOUNT INFORMATION:

**PERSON RESPONSIBLE FOR ACCOUNT:**

**Name:** _____
Last Name First Name

**Address:** _____

_____

**Phone:** _____ Home ◯ Cell ◯ Work ◯

**Dental Insurance Company:** _____

**ID#:**_____**Group#**_____**Phone#**_____

**Policy Holder:**_____ **Policy Holder DOB:**_____

**In the event of an Emergency, whom do we contact?**

**Name:** _____ **Relationship:**_____

**Phone #:** _____

**Who is your medical Doctor?** _____

**Medical Doctor Phone Number:** _____

# General Consent

Thank you for choosing our office for your dental care. We will work with you to help achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include relief of pain, the ability to chew properly and the confidence with social interaction that a pleasant smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or 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, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw tenderness, or in predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does.

Please feel free to ask questions in regards to all dental procedures that are recommended to you.

_____ _____

Patient Signature or Parent/ Guardian Signature Date

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## MEDICAL HISTORY

Please rate the health of your mouth.

☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

Have you had your wisdom teeth extracted?

◯ Yes ◯ No

Do you like the appearance of your smile? If no, what would you change?

* ☐ Yes ☐ No ☐ Whiter Smile ☐ Straighter Smile

Do your gums bleed when brushing/ flossing?

◯ Yes ◯ No

Do you clench or grind your teeth?

◯ Yes ◯ No

Please rate your anxiety level with dental treatment

◯ None ◯ Slight ◯ Moderate ◯ High ◯ Very High

Please list concerns you have with the health of your mouth, teeth, gum tissue, or sensitivity?

When was your last dental visit?

Are you currently under the care of a physician?

◯ Yes ◯ No

For what?

Have you ever been told you need a Pre-Med before dental appointments?

◯ Yes ◯ No

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Have you ever been diagnosed with the Hepatitis virus? If so, what type?

◯ A ◯ B ◯ C

Do you have a history of tobacco/ marijuana use?

☐ Cigars ☐ Chewing tobacco ☐ Cigarettes ☐ Marijauna

Are you pregnant or nursing?

◯ Yes ◯ No

Please check the following that apply to family history.

☐ Heart disease ☐ Diabetes ☐ Gum Disease

**Please check all that apply to you**

| | | |
|---|---|---|
| ☐ AIDS | ☐ Alcohol/Drug Abuse | ☐ Allergies |
| ☐ Allergy Clindamycin | ☐ Allergy Minocycline | ☐ Allergy Tetracycline |
| ☐ Allergy to Ceclore | ☐ Allergy to Zithromax | ☐ Allergy/Anesthetic |
| ☐ Anemia | ☐ Anxiety | ☐ Arthritis |
| ☐ Artificial Joints | ☐ Asthma | ☐ Blood Disease |
| ☐ Cancer | ☐ Chemotherapy Tx | ☐ Codeine Allergy |
| ☐ Depression | ☐ Diabetes | ☐ Dizziness |
| ☐ Emphysema | ☐ Epilepsy | ☐ Excessive Bleeding |
| ☐ Fainting | ☐ Glaucoma | ☐ Growths |
| ☐ Hay Fever | ☐ Head Injuries | ☐ Heart Disease |
| ☐ Heart Murmur | ☐ Hepatitis | ☐ High Blood Pressure |
| ☐ High Cholesterol | ☐ HIV | ☐ HIV |

- [ ] Jaundice
- [ ] Kidney Disease
- [ ] LATEX ALLERGY
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Migraines
- [ ] Mitral Valve
- [ ] Morphine allergy
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] PRE MED
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Thyroid Disease
- [ ] Tobacco Use
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Please list any other allergies you have.

Please list all medications and supplements you are currently taking, prescribed or non prescribed.
(If you have a written list you can give it to the receptionist and she will copy it for you.)

Todays Blood Pressure

- [ ] By checking this box I acknowledge that all information reported is up to date, accurate, and to the best of my knowledge.

Signature: _____ Date:

Response Date: