GORDON WEST D.D.S.
Aesthetic & General Dentistry
1140 W. South Boulder Rd. #201
Lafayette, CO 80026
(303) 665-5335

New Patient Information

Please take a moment to enter your information to help us ensure the quality of your care is excellent

Patient Name: _____
Last First MI Preferred Name

Title: MR. MS. MRS. Gender:_____ Family Status: Married Single Child Other

Birth date: _____ SS#:_____

Email Address: _____ Previous Visit_____

Phone #:_____
Home Work Mobile

Address: _____
Street City State Zip

Whom may we thank for referring you to our office: _____

In the event of an emergency whom should we contact? _____

Relation to emergency contact_____ Phone #_____

Insurance Information

Insurance Company_____ Phone #_____

Subscriber_____ SS#/ID_____

Subscriber DOB: _____ Relation to subscriber_____

Subscriber's employer _____

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Your Primary Care Physician's Name and Phone number_____

Dental Information:

Reason for today's visit: _____

Are you in pain? Yes No If so, where and symptoms_____

_____

Please indicate any of the following problems:

- Discomfort, clicking or popping in jaw
- Sensitive tooth, teeth or gums
- Lost/Broken filling
- Ringing in ears
- Stained teeth
- Bad breath
- Red. Swollen or bleeding gums
- Blisters/sores in or around the mouth
- Teeth grinding
- Broken/chipped tooth
- Locking Jaw
- Other

Do you require pre-medication? Yes No

Are you hearing impaired? Yes No

Do you struggle with sleep apnea? Yes No

Previous dentist name and phone number:
_____

Last dental exam: _____ Were x-rays taken? Yes No

How would you rate you smile? (1 worst/10 best)_____

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Medical History

__PREMED REQUIRED	__Allergies-Other	__Allergy-Sulfa	__Allergy-Anesthetic
__Allergy-Aspirin	__Allergy-Codeine	__Allergy-Epinephrine	__Allergy-LATEX
__Allergy-Penicillin	__Allergy-Tetracycline	__Anemia	__Arthritis
__Arthritis/Rheumatism	__Aspirin Daily	__Asthma	__Bisphosphonate PILL
__Bisphosphonates IV	__Blood Disease	__Blood Thinners	__Cancer
__Cholesterol	__Diabetes	__Dizziness	__Drug/Alcohol Abuse
__Eating Disorders	__Epilepsy	__Excessive bleeding	__Glaucoma
__Hay Fever	__Head Injuries	__Heart Attack	__Heart Disease
__Heart Murmur	__Hepatitis ____	__High Blood Pressure	__HIV/AIDS/ARC
__Jaundice	__Joint Replacement	__Kidney Disease	__Liver Disease
__Mental Disorders	__MVP	__Nervous Disorders	__Other
__Pacemaker	__Phen-fen/Redux	__Pregnancy	__Radiation Treatment
__Respiratory Problems	__Rheumatic Fever	__Seizures	__Sinus Problems
__Stomach Problems	__Stroke	__Sulfa	__Thyroid
__Tobacco Use	__Tuberculosis TB	__Tumors	__Ulcers
__None of the above			

Other: _____

_____

If you use tobacco: How long? _____ How much?_____

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Please list all medications that you are currently taking: _____

_____

_____

Please list any other surgeries, medical conditions or additional allergies you have or have had: _____

_____

_____

Additional notes/concerns: _____

_____

_____

FOR WOMEN ONLY:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Authorization:

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on the behalf of my dependents (if any).

If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

_____

Signature of patient, parent, or guardian:

_____ _____

Relationship to patient: Date

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HIPPA-Acknowledgement Form

Patient Name: _____
Last First MI Preferred

I have received a copy of this office's Notice of Privacy Practices.

_____
Signature of patient and or legal guardian

_____ _____
Relationship to patient Date

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining acknowledgement

___ Other

Please specify: _____

_____

_____ _____
Signature of employee Date

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Office Policies

Patient Name: _____
Last First MI Preferred

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The following is our appointment and financial policies, which we ask you to read and sign prior to treatment.

Appointment Policy:

A scheduled appointment is a commitment of time between you and our practice. We have reserved time just for you. When appointments are missed or cancelled, that time is permanently lost. We ask that when you schedule an appointment, you make every effort to keep that commitment. We require a minimum two working day notice to cancel or reschedule the appointment. If you miss or cancel two appointments, you will be asked to prepay before we can reschedule the appointment. The charge for an hour long missed appointment is $35.00, a two hour missed appointment is $75.00, and a three hour missed appointment is $150.00. We will ask for a credit card number to have on file, and if you miss or cancel the appointment, your portion will be charged to the credit card.

Insurance Policy:

Your insurance is a contract between you and your insurance company. We are not a party to that contract. Be sure to read and understand your insurance policy. We cannot bill your insurance company without the proper insurance information. Make sure we are provided with the current filing information. We will be happy to file your insurance for you however; we require that you pay your portion at the time of services. This will be 40-60% of the total bill depending on your insurance coverage. If your insurance company has not paid for treatment within 60 days, you will be responsible for the balance in full. Be aware that you are responsible for all treatment received but not covered by your insurance company. As a courtesy to our patients we do our best to estimate co-payments and patient portions however, ultimately the balance is the responsibility of the patient regardless of insurance coverage.

Interest:

We reserve the right to assess an annual 18% interest charge on all overdue accounts 60 days after the original charge.

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Collection and Attorney fees:

Any account that has been delinquent for 90 days may be turned over to our collection agency. The patient or responsible party agrees to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon 18% per annum on all such amounts outstanding. 35% of the total balance due will also be added to the overdue balance which pays for collection cost.

If my account goes into default, I agree to pay all collection fees and collection costs including, but not limited to, attorneys' fees added for the collection of my account, whether or not suit is filed and whether or not such costs are paid or incurred, prior to or after the entry of a judgment.

Thank you for understanding our office policies. Please let us know if you have any questions or concerns.

_____ I understand and agree to this office policy.
Initial

_____
Signature of patient, parent, or legal guardian

_____ _____
Relationship to patient Date

_____ _____
Witness Date