bdg
boulder dental group
702-293-0205 | 806 Buchanan Blvd. #108, Boulder City, NV 89005 | Vons Shopping Center

HEALTH HISTORY

Patient Name ____ ______________________

Physicians Name______________________ Phone #______________ Date of last visit____________

Circle to indicate if you have/had any of the following:

AIDS/HIV	Epilepsy	Respiratory Disease
Anemia	Fainting or dizziness	Rheumatic Fever
Arthritis, Rheumatism	Glaucoma	Scarlet Fever
Artificial Heart Valves	Headaches	Tobacco/Alcohol use
Artificial Joints	Psychiatric Problems	Sinus Trouble
Asthma	Heart Problems	Skin Rash
Back/Neck Problems	Hepatitis Type ___	Special Diet
Abnormal Bleeding	Herpes	Stroke/Heart Attack
Surgery	High/low Blood Pressure	Unexplained weight loss
Chemical Dependency	Osteoporosis Medication	Swollen Neck Glands
Cancer/Tumors	Jaw Pain	Thyroid Problems
Chemotherapy	Liver Disease	Tuberculosis
Circulatory Problems	Taken Fen-Phen	Radiation Treatment
Diabetes	Mitral Valve Prolapse	Stomach problems/Ulcers
Cortisone Treatments	Emphysema	Venereal Disease
Persistent Cough	Pacemaker	Other __________________

Allergies to: Penicillin/Antibiotics Latex Codeine Local Anesthetics Other _____________

Dental History

Reason for Today's visit____

Date of Last dental Visit and X-rays ___________________

Circle to indicate if you want your dentist to discuss the items below:

Bad Breath	Bleeding/Swollen Gums	Blisters on lips or mouth
Burning tongue	Clicking or Popping Jaw	Dry Mouth
Grinding teeth	Osteoporosis Therapy	Loose teeth or broken fillings
Orthodontic Treatment	Periodontal Treatment	Tooth sensitivity to cold/hot/sweets

Women Only:

Are you Pregnant Yes/No Are you taking Birth control pills Yes/No Are you Nursing? Yes/No

List any medications you are currently taking and the reason you are taking the medication.
(If list is extensive please list on another sheet)

Patient/Parent Signature ____ Date _____________

Doctor's Signature____ Date _____________

PATIENT REGISTRATION

Patient First Name_____________________Initial_____Last______________________________

Social Security Number __________________________Birthdate _________________________

Home Phone _____________________ Cell or Work Number ______________________

Street Address________________________City________________State______ Zip_________

(Circle) Male or Female Employer ____

Employer Address ____

Spouse Name___________________________________Birthdate_________________________

Social Security Number ___________________________ Employer _______________________

In case of emergency who should be notified? _______________________ Phone _____________

Who is responsible for this account? _____________________ Relationship to patient __________

Primary Insurance __________________________________ Phone Number ________________

Subscriber_______________________________ Group Number __________________________

Secondary Insurance __________________________________ Phone Number ________________

Subscriber_______________________________ Group Number __________________________

Assignment and Release
I certify that I, and/or my dependent(s), have insurance coverage with the above mentioned insurance company and assign directly to Boulder Dental Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that payment is due at the time of treatment. I understand that filing a claim with my insurance company does not relieve me from my responsiblilty for the payment of all charges. I authorize the use of my signature on all insurance submissions.

HIPPA
The above named dentist may use my health care information or minor/child's information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I have been given the "notice of privacy practices" brochure, read and understand that it covers federal law pertaining to privacy practices. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature for Assignment and Release and HIPPA _______________________________________ Date ________

How did you hear about us? (Boulder Dental Group)____

Are you interested in a ViziLite Oral cancer screening? (Circle) YES NO

BILLING AND INSURANCE POLICY

Boulder Dental Group has several options to enable you to receive your proper dental care. All fees are to be paid at the time services are rendered. As a convenience to our patients with dental insurance, our office will submit the required information for payment. We accept most insurance plans. Many insurance companies will not cover 100% of all dental expenses. Your portion not covered by insurance will be due at the time services are rendered. The patient is still the responsible party regarding all dental fees. We will do our best to approximate the patient portion, but please keep in mind that these figures are estimates and true portion amounts will not be determined until final payment is received. Please understand that dental insurance is a contract between the patient and the insurance carrier, not the carrier and the dentist.

We want your visit to be a pleasant experience. We will do everything to make sure that all fees for service are billed efficiently and in a timely manner to ensure the proper handling of your account. We thank you for your confidence in choosing our office for all your dental needs.

Signature__________________________ Date____________________

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PHYSICIAN CONSENT

Physician ______________________________________ Date ___________

Patient ____

Possible treatment(s) are: Deep cleanings, Extractions, Fillings, Crowns and Root canals. Medications typically given are : Pain medication, Local anesthetics with or without epinephrine and antibiotics.

Dr. Huxford of Boulder Dental Group wants to know if he can perform dental work on the patient listed above. Routine dental work will be performed with additional procedures listed below:
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Physician comments:

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Physician Signature __________________________________ Date __________