pearl street dental

laser & microscopic enhanced dentistry

## PERSONAL INFORMATION

| | | |
|---|---|---|
| First Name: | Last Name: | Middle Initial: |
| Preferred Name: | | |
| Sex: ☐Female ☐Male | Date of Birth: | |
| Marital Status: ☐Married ☐Sin ☐Divorced ☐ Separated ☐Widowed | | |
| Address: | | |
| City: | State: | Zip: |
| Home #: | Cell #: | Work #: |
| Social Security #: | E-mail Address: | |
| Preferred Contact : ☐Email | ☐Text Phone ☐Phone | |

**Whom may we thank for referring you?**

**Do you have other family members that are seen by us?**

**In the event of an emergency, whom should we contact?**

| | | |
|---|---|---|
| First Name: | Last Name: | Middle Initial: |
| Relationship: | | |
| Home #: | Cell #: | Work #: |

**If you are not responsible for your account, please list the individual that will be responsible**

| | | |
|---|---|---|
| First Name: | Last Name: | Middle Initial: |
| Relationship: | | |
| Home #: | Cell #: | Work #: |
| Email: | Employer: | |
| Billing Address: | | |

## PRIMARY DENTAL INSURANCE INFORMATION FOR INSURED

| | | |
|---|---|---|
| Name of Insured: | Relationship to Insured: □Self □Spouse □Child □Other | |
| Group #: | Subscriber ID: | |
| Social Security #: | Date of Birth: | |
| Insurance Company: | | |
| Address: | | |
| City: | State: | Zip: |
| Home #: | Cell #: | Work #: |
| Employer: | | |

## DENTAL AND MEDICAL HISTORY

**Patient Name** _____ **DOB** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

**Why have you come to see Dr. Higgins today?**

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| |

| Please answer the following | YES | NO |
|---|---|---|
| Are you experiencing dental pain | □ | □ |
| Do you floss daily | □ | □ |
| Do you brush daily | □ | □ |
| Do your gums bleed | □ | □ |
| Would you like fresher breath | □ | □ |
| Would you like whiter teeth | □ | □ |

**Do you use anything in addition to your brushing and flossing?**

| |
|---|
| |

**What type of tooth brush are you using?**

Hard ☐ Medium ☐ Soft ☐

**Why did you leave your previous dentist?**

**Do you have a personal primary care physician?**

**Have you ever been hospitalized, major operation or neck injury?**

| Please answer the following | YES | NO |
|---|---|---|
| Do you take, or have you taken **Phen-fen** or **Redux** (weight-loss medication) | ☐ | ☐ |
| Have you taken **Fosamax** | ☐ | ☐ |
| Have you taken other **Bisphosphonates** | ☐ | ☐ |
| Do you use **Tobacco** | ☐ | ☐ |
| Do you use **Marijuana** | ☐ | ☐ |
| Do you need to **pre-medicate** with **antibiotics** before dental treatment | ☐ | ☐ |

**Are you currently under a physician's care? If yes, please explain?**

| Do you have ALLERGIES to the following | YES | NO |
|---|---|---|
| Aspirin | ☐ | ☐ |
| Penicillin | ☐ | ☐ |
| Codeine | ☐ | ☐ |
| Acrylic Metal | ☐ | ☐ |
| Latex | ☐ | ☐ |
| Local Anesthetics | ☐ | ☐ |
| Epinephrine | ☐ | ☐ |

| | |
|---|---|
| **Please list additional drugs/materials that cause allergic reactions** | |

**Are you taking prescription, over-the-counter drugs, herbal remedies, vitamins or minerals?**

| |
|---|
| |

| **WOMEN:**<br>**Please answer the following** | **YES** | **NO** |
|---|---|---|
| Are you **pregnant** or **trying to get pregnant** | ☐ | ☐ |
| Are you taking **oral contraceptives** | ☐ | ☐ |
| Are you currently **nursing** | ☐ | ☐ |

| **Please answer the following** | **YES** | **NO** |
|---|---|---|
| **AIDS/HIV Positive** | ☐ | ☐ |
| **Alzheimer's Disease** | ☐ | ☐ |
| **Anaphylaxis** | ☐ | ☐ |
| **Anemia** | ☐ | ☐ |
| **Angina** | ☐ | ☐ |
| **Arthritis** | ☐ | ☐ |
| **Artificial Heart Valve** | ☐ | ☐ |
| **Artificial Joint** | ☐ | ☐ |
| **Asthma** | ☐ | ☐ |
| **Breathing Problem** | ☐ | ☐ |
| **Blood Disease** | ☐ | ☐ |
| **Blood Transfusion** | ☐ | ☐ |
| **Bruise Easily** | ☐ | ☐ |
| **Cancer** | ☐ | ☐ |
| **Chemotherapy** | ☐ | ☐ |
| **Chest Pain** | ☐ | ☐ |
| **Cold Sores** | ☐ | ☐ |
| **Congenital Heart Disorder** | ☐ | ☐ |
| **Convulsions** | ☐ | ☐ |

| | | |
|---|---|---|
| **Cortisone Medication** | ☐ | ☐ |
| **Diabetes** | ☐ | ☐ |
| **Drug Addiction** | ☐ | ☐ |
| **Emphysema** | ☐ | ☐ |
| **Epilepsy** | ☐ | ☐ |
| **Excessive Bleeding** | ☐ | ☐ |
| **Excessive Thirst** | ☐ | ☐ |
| **Fainting Spells/Dizziness** | ☐ | ☐ |
| **Frequent Cough** | ☐ | ☐ |
| **Frequent Low Blood Pressure** | ☐ | ☐ |
| **Glaucoma** | ☐ | ☐ |
| **Genital Herpes** | ☐ | ☐ |
| **Gout** | ☐ | ☐ |
| **Hay Fever** | ☐ | ☐ |
| **Headaches** | ☐ | ☐ |
| **Heart Attack/Failure** | ☐ | ☐ |
| **Heart Murmur** | ☐ | ☐ |
| **Heart Pacemaker** | ☐ | ☐ |
| **Heart Trouble/Disease** | ☐ | ☐ |
| **Hemophilia** | ☐ | ☐ |
| **Herpes** | ☐ | ☐ |
| **Hepatitis A** | ☐ | ☐ |
| **Hepatitis B** | ☐ | ☐ |
| **Hepatitis C** | ☐ | ☐ |
| **Hepatitis D** | ☐ | ☐ |
| **Hepatitis** | ☐ | ☐ |
| **High Blood Pressure** | ☐ | ☐ |
| **Hives or Rash** | ☐ | ☐ |
| **Hyperglycemia** | ☐ | ☐ |
| **Hypoglycemia** | ☐ | ☐ |
| **Irregular Heart Beat** | ☐ | ☐ |
| **Kidney Problems** | ☐ | ☐ |
| **Leukemia** | ☐ | ☐ |
| **Liver Disease** | ☐ | ☐ |
| **Lung Disease** | ☐ | ☐ |

| | | |
|---|---|---|
| **Mitral Valve Prolapse** | ☐ | ☐ |
| **Pain in Jaw Joints** | ☐ | ☐ |
| **Parathyroid Disease** | ☐ | ☐ |
| **Psychiatric Care** | ☐ | ☐ |
| **Radiation Treatments** | ☐ | ☐ |
| **Recent Weight Loss** | ☐ | ☐ |
| **Rheumatic Fever** | ☐ | ☐ |
| **Rheumatism** | ☐ | ☐ |
| **Renal Dialysis** | ☐ | ☐ |
| **Scarlet Fever** | ☐ | ☐ |
| **Sickle Cell Disease** | ☐ | ☐ |
| **Shingles** | ☐ | ☐ |
| **Sinus Trouble** | ☐ | ☐ |
| **Spina Bifida** | ☐ | ☐ |
| **Stoke** | ☐ | ☐ |
| **Stomach/Intestinal Disease** | ☐ | ☐ |
| **Swelling of Limbs** | ☐ | ☐ |
| **Thyroid Disease** | ☐ | ☐ |
| **Tonsillitis** | ☐ | ☐ |
| **Tuberculosis** | ☐ | ☐ |
| **Tumors or Growths** | ☐ | ☐ |
| **Ulcers** | ☐ | ☐ |
| **Yellow Jaundice** | ☐ | ☐ |

**Please list all anything else you would like us to know**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**SIGNATURE OF PATIENT, PARENT, or GUARDIAN**

_____ DATE _____

**APPOINTMENT AND CANCELLATION POLICY**

Updated 01/19/2017

Appointments that have been broken within a few hours to minutes of the scheduled time and no shows have become quite a problem in the last few months. It is unnecessarily crippling the business. It puts me, as the Dentist and Owner in an awkward but necessary position of charging a fee for broken appointments. I have not had a written policy in the past, but one is necessary now. I have spent considerable time and effort to establish a state of the art dental office that delivers the finest, most comfortable dental care a person can get. We really try to exceed everyone's expectation of general dentistry. My time, and my staff's time are the greatest asset I have, I do not want to waste them.

**ALL PATIENTS ARE EXPECTED TO SHOW UP ON THE SCHEDULED DATE AT THE SCHEDULED TIME**. If an appointment cannot be kept and needs to be broken or changed, a 48 hour notice must be given. **If an appointment is broken within the 48 hour time frame a $50.00 SURCHARGE PER HOUR OF THE MISSED APPOINTMENT** will be administered. Our Front Desk Staff will take care of scheduling via the phone Mondays 9am-12pm. Tuesday, Wednesday and Thursday all day from 7:30am-4:30pm. We will always do our best to accommodate you.

The surcharge will need to be paid before another appointment can be made. After three broken appointments a patient will be dropped from the Practice, as they are showing very little regard for our time and are taking advantage of the business.

Most of our patients are very good to us and certainly do value our time and efforts on their behalf. These are the patients who will benefit the most from these new policies.
**OF COURSE EXCEPTIONS CAN AND WILL BE MADE FOR EMERGENCIES AND OTHER UNFORESEEN CIRCUMSTANCES. WE ARE MORE THAN REASONABLE IN THIS REGARD.**

I sincerely hope you understand my motivation for doing this.

Sincerely,
Dr. Elliott Higgins DMD

I, _____, understand that I will be responsible for keeping my appointment as written on my appointment card or most recent contact by Pearl Street Dental. I will pay a $50.00 surcharge per hour for missed or last minute cancellations as described above before making another appointment.

Signature: _____
Date: _____

**Consent for Use and Disclosure of Health Information (HIPAA)**

**Section B: PATIENTS PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice is available at your request in our office. We encourage you to request a copy and read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Jennifer Dillon, Privacy Officer, Pearl Street Dental
Address: 2575 Pearl Street Dental
Phone: 303-443-3771

**Right to Revoke**: You will have the right to revoke this Consent at any time by providing our office with a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**Consent**: I, the patient and/or representative*, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____
Date: _____