551 Kokopelli Blvd. · Kokopelli Professional Plaza
Fruita, CO 81521 · 970-858-9511
www.lybrookdental.com

WELCOME

Date:_____
Legal Name:_____Male_____Female_____
I prefer to be called _____Married__Single__Divorced__Widowed__Separated__
Birth date:_____ Age:_____
Home Address:_____City:_____Zip:_____

Home#:_____Work#:_____Cell#:_____
Social Security#_____
Driver's License#_____
e-mail:_____
May we confirm your appointments using your e-mail address? Yes_____ No_____

Employer:_____How long at job_____
Address:_____

Whom may we thank for referring you?_____

Parent or Spouse Information
His/Her Name:_____Home #:_____Work#:_____
Soc. Sec. #:_____Birthdate:_____
Employer:_____

Person Responsible for Account:_____
Home#:_____Work#:_____Cell #:_____
Soc. Sec. #_____Drivers License#:_____

Dental History
Previous/Present Dentist:_____Last Visit Date_____

Why have you come to the dentist today?_____
_____

Are you currently in pain? Yes_____ No_____

Have you ever had a serious/difficult problem associated with any previous dental work?
Yes_____ No_____
Do you or have you ever-experienced pain/discomfort in your jaw joint (TMJ, TMD)?
Yes_____ No_____

Your current Dental Health is: Good__ Fair__ Poor__

Do you like your smile? Yes_____ No_____
Do your gums ever bleed? Yes___ No___ How many times a week do you floss: _____
How many times a day do you brush? _____ Type of bristles? Hard__ Medium__ Soft__

Medical History

Do you have a personal Physician? Yes__ No__ Physician's Name:_____
Phone#_____ Last Visit Date:_____
In case of emergency, whom should we contact?
His/Her Name?_____ Relationship:_____
Home#:_____Work#:_____Cell#:_____

Your current physical health is: Good_____ Fair_____ Poor_____
Are you currently under the care of a physician? Yes_____ No_____
Are you taking any prescription/over the counter drugs? Yes_____ No_____
Please list each one:_____
_____
_____

For Women only:

Are you taking birth control pills? Yes_____ No_____
Are you pregnant? Yes_____ No_____ Week #:_____
Are you nursing? Yes_____ No_____

Please list any medical condition(s) you now have or have ever had:_____
_____
_____

Are you allergic to any of the following:

Aspirin ___ Erythromycin ___ Codeine ___ Latex Gloves ___ Penicillin ___
Jewelry/Metal ___ Dental Anesthetics ___ Tetracycline ___ Other (explain)_____

Please list any drugs you are allergic to:_____
_____
_____

Please CIRCLE all of the medical problems you currently have or have ever had:

Artificial Joints	Abnormal Bleeding	Fever Blisters/Herpes	Shingles
Blood Transfusions	Anemia	Glaucoma	Sinus Problems
Cong. Heart Defect	Asthma	Heart Attack	Stroke
Heart Murmur	Arthritis	Heart Trouble	Ulcers
Heart Pacemaker	Cancer	Hemophilia	Venereal Disease
Mitral Valve Prolapse	Chemotherapy	High/Low Blood Pressure	Diabetes
Rheumatic Fever	Colitis	Hospitalized for any reason	Gluten Intolerance
Heart Surgery	Difficulty Breathing	Kidney Problems	Osteoporosis
Hepatitis	Drug/Alcohol Abuse	Psychiatric Problems	Thyroid
HIV/AIDS	Emphysema	Radiation Treatment	Acid Reflux
Tuberculosis (TB)	Epilepsy	Severe/Frequent Headaches	

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I any need during diagnosis and treatment with my informed consent.

*SIGNATURE:*_____ _____
Date

***PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

Doctor's Comments:

I verbally reviewed the medical/dental information above with the patient named herein.
Date Comments Signature
_____
_____
_____

Financial Policy

We strongly feel that all patients deserve from us the finest dental care that we can provide. You will benefit from the high standards we have set for delivering the utmost quality of dental treatment available. We also feel that when financial arrangements are discussed and agreed upon, everyone benefits. Accordingly, we have prepared this information to acquaint you with our financial policy.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGMENTS HAVE BEEN MADE.

Please indicate below the method of payment that you will use to pay for the dental treatment.

Payment Options:

_____Cash or Check

_____Visa/Master Card/American Express/Discover

Extended Payment Options:

_____Capital One Healthcare Finance – Credit Application Required

Dental Insurance

Our office will do everything possible to help you understand and make the most of your dental insurance. We do accept insurance benefits as partial payment for treatment along with your payment of the estimated patient portion cost. You are responsible for all fees and charges for your account. Please be assured our staff will do all that we can do to help you receive maximum reimbursement from your insurance company.

Insurance Information:

Primary Insurance Carrier: _____

Group Number:_____

ID Number:_____

Insurance Phone Number:_____

Missed Appointment Policy

Unforeseen events sometimes require missing an appointment. If you need to cancel or reschedule an appointment, we respectfully request notification of at least **24 hours in advance** to avoid a charge. If you fail to arrive for your appointment and have not notified us **24 hours in advance**, your account may be assessed a Missed Appointment Fee of $50.00.

Thank you for choosing us to meet your dental goals. Our commitment to quality is equal only by our commitment to exceptional customer service. Our staff is here to assist you in anyway we can. Please let us know if you have any questions or concerns.

_____

I have read the Lybrook Dental Center Financial Policy and I understand and agree to this policy.

_____

Signature of Patient or Responsible Party Date

GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you 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 and social interaction that a pleasing 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
2. allergic or sensitivity reactions.
3. Long-term numbness (paresthesia). Local anesthetic, or is administration,
4. while almost always adequate to allow comfortable care, can result in
5. transient, or in rare instances, permanent numbness.
6. Muscle or joint tenderness. Holding one's mouth open can result in
7. muscle or Jaw joint tenderness, or in a predisposed patient, precipitate a
8. TMJ disorder.
9. Sensitivity in teeth or gums, infection or bleeding.
10. Swallowing or inhaling small objects.

While we follow procedural guidelines that 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 regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page:

_____ _____

Patient's Signature Date

_____ _____

Parent's Signature (if minor patient) Date

LYBROOK DENTAL

Innovative Comprehensive Dentistry

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