LYBROOK DENTAL

Innovative Comprehensive Dentistry

Welcome to our wonderful family of patients. Thank you for selecting us as your personal dental care team. We will strive to make your relationship with us a pleasant and rewarding one.

A firm foundation is needed upon which we can base recommendations for your dental health. Therefore, we will complete a thorough oral health and cosmetic dental examination during your initial appointment.

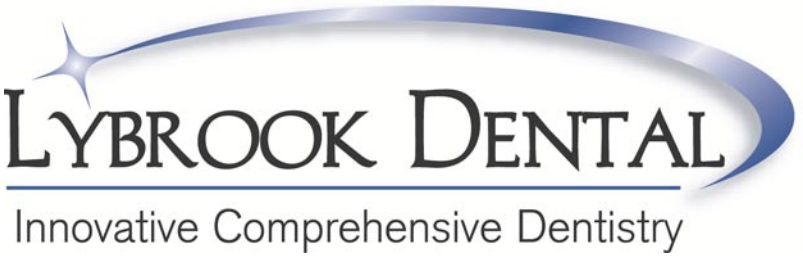
Preventive dentistry is the most important service we have to offer you. We will show you how to control your own dental health and maintain your beautiful smile. Preventive examinations on a regularly scheduled basis will give you the maximum opportunity for long-term dental health.

Good communication is essential to forming a satisfactory relationship. If you ever have a concern about any treatment, fee, or service, please feel free to discuss it immediately and openly with any of us. We would really appreciate this. We welcome your comments and suggestions, and want to do everything we can to make your visit a pleasant experience.

Creating and maintaining your oral health is our primary goal. Thank you for giving us the opportunity to pursue this goal with you.

Sincerely,

Drs. Carol and Scott Lybrook



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
_____
_____
_____

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

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Lybrook Dental Center 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 ARRANGEMENTS HAVE BEEN MADE.

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

Payment Options:

You can choose from:

_____Cash or Check

_____MasterCard, American Express, Discover Card or Visa

Extended Payment Options:

_____ NO INTEREST Payment Plan from Care Credit (6 months)

*Allows you to make payments over time with NO INTEREST**, if paid on time and in full**

*Convenient, low monthly payment

*No annual fees or pre-payment penalties

Dental Insurance:

Our office will do everything possible make the most of your dental insurance benefit. 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 our account. All insurance plans are different and may have limitations. These may include but are not limited to waiting periods, missing tooth clause, downgrade on services, exceptions and limitations of your specific plan for which we cannot be held responsible. Any insurance portion that has not been paid after 90 days will be billed to the patient.

Dental Insurance Information:

Employee/Policy Holder Name:_____ DOB:_____

Employer:_____ Group Number:_____

Primary Dental Insurance Carrier:_____

ID Number:_____ Insurance Carrier Phone Number:_____

Please let us know if you have any questions or concerns. We are here to help you in any way we can.

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

_____

Patient, Parent or Guardian Signature Date

Lybrook Dental Center Missed Appointment Policy

At Lybrook Dental Center, we are committed to providing all of our patients with exceptional care. When you have an appointment in our office, that time has been reserved exclusively for you! When a patient cancels without giving enough notice or fails to come for a reserved appointment it prevents another patient from being seen who is in need of dental care. Unforeseen events sometimes require a change of appointment. If you need to cancel or reschedule an appointment, we respectfully request notification of at least **48 hours in advance** to avoid a charge. If you fail to arrive for your appointment and have not notified us **48 hours in advance**, your account may be assessed a Missed Appointment Fee of $50.00 **PER HOUR** of reserved time.

An appointment is considered missed/broken for one or more of the following reasons:

1. **Failure to show up** for a reserved appointment
2. Cancelling a reserved appointment **without 48 hours notice**
3. Showing up more than **15 minutes late** for a reserved appointment

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

_____

Patient, Parent or Guardian Signature Date