Welcome to Our Practice!

Please completely fill out the following forms.

Patient Information

Name:_____ Date of Birth: ____/____/_____

Address:_____ City:_____ State:_____

Zip Code:_____ Home Phone:_____

Cell Phone:_____ Work Phone: _____

E-Mail Address:_____ Social Security Number: _____

What is your preferred method of communication? Cell Home Work E-mail May we text you?_____

Emergency Contact:_____ Relationship:_____

Phone number:_____

How did you hear about our practice? (Please circle) Friend Family Member Our Website/Google

Insurance Company Drove By/Live in the Area Other: _____

If someone referred you, who can we thank for the referral?_____

Patient Employment Information

Occupation:_____ Employer:_____

Do you have dental insurance? Yes No *If yes please fill out "Dental Insurance" information section below and please provide your insurance card(s) to the front desk.

Financial Responsible Party *Please complete if someone other than patient

Name:_____ Date of Birth: ____/____/_____

Address (if different from above): _____ City: _____

State:_____ Zip Code:_____ Home Phone:_____

Cell Phone:_____ Work Phone: _____

Relationship to Patient: _____ Social Security Number: _____

Employer:_____

Dental Insurance *Please provide your insurance card to the front desk

Insurance company:_____ Group Number:_____

Plan Number:_____ Insurance Company Phone Number: _____

Subscriber/Member or Policy Holder Info Name:_____

Date of Birth: ____/____/_____ Social Security Number: _____

Financial Agreement and Office Protocols

We understand that sometimes situations arise that require rescheduling of your appointment. If you do need to reschedule, please contact our office preferably two business days before your scheduled appointment time. If an appointment is broken in less than two business days, or you do not show up or fail to notify our office about your appointment, a $50 per hour of reserved/ scheduled appointment time will be charged. If you arrive late for your scheduled appointment, you may be asked to reschedule if there is not enough time to complete your procedure. Rocky Mountain Dental Arts makes every effort to be on time for your appointment. If you are going to be late for an appointment, please promptly notify our office.

As a courtesy to our patients, we will submit your claims to your insurance company and collect the estimated patient portion, including any deductibles for your care at time of service. Some procedures may require a preauthorization by your insurance company prior to beginning treatment. Some dental services may not be a covered benefit of your insurance. The patient portion of payment is due when services are rendered.

All account balances over 60 days are subject to a 1.5% per month finance charge (18% APR). There is a $35 fee for any returned checks.

Please note that all co-pays and deductibles are only estimates based upon the information provided to us by your insurance company. Your insurance company will pay the rates specified in your insurance contract, Our estimated fees are based on the explanation of benefits provided by your insurance company. It is the patient's and/or the policy holder's responsibility to be aware of any restrictions, limitations, exclusions, alternate benefits, allowables, and frequency of treatment. It is important for you the patient, policy holder and/or responsible party to become familiar with and aware of your specific plan benefits and guidelines. You are responsible for any balance left unpaid by your insurance company.

To assist our patients, we offer the following methods of acceptable payment: Cash or check, Visa, MasterCard or Discover. We will also accept your HSA (Health Savings Account) or Flex-Spending Benefit Card. For patients that qualify, we offer a 6 or 12 month interest free payment plan (when balance is paid within the 6 or 12 month period) through Care Credit. There are no upfront costs, pre-payment penalties or annual fees associated with Care Credit to our patients. As a professional courtesy, we will offer a 10% cash pay, senior citizen (over 65), active duty military, and first responder discount for patients without dental insurance.

At Rocky Mountain Dental Arts we promise to you that we will never be guided on your treatment needs based on your insurance plan. We will always talk with you first about what dentistry you may need, make sure you understand the dentistry, and then will work with you on a financial arrangement. Dental insurance is a great benefit and we will work with you to maximize your benefits from your plan; insurance is a method of payment, not a method of treatment.

I authorize and request my insurance company to pay directly to Rocky Mountain Dental Arts any insurance benefits due to Rocky Mountain Dental Arts for services rendered. I verify that I am responsible for all charges not covered by my insurance company and agree that any amounts not paid by my insurance company or companies within 45 days of initial date of service, will be transferred to me and are due to promptly to Rocky Mountain Dental Arts.

HIPPA Information – Notice of Privacy Practices

You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment activities and healthcare operations of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We will gladly provide you with a copy, in its entirety of the Notice of Privacy Practices upon your request. We may disclose your health information to a physician or other healthcare provider providing treatment to you. You have a right to your health information.

I grant my permission to you or your assignees, to telephone me at home, on my cell phone or at my place of employment to discuss matters related to this form.

Matters regarding my dental care may also be discussed with the following person(s):_____

_____

May we leave messages regarding your treatment? Yes No

May we use photos and information about your treatment for teaching and demonstration purposes? Yes No

Consent for Treatment

I authorize Alexandra Blomquist DDS and or such persons as she may appoint, to provide treatment, to perform or assist in the performance of dental treatment or procedures at Rocky Mountain Dental Arts PC. I consent to the administration of any anesthetic that Dr. Alexandra Blomquist or her appointees deem necessary to provide the proper treatment and to help my dental treatment to be as comfortable as possible. I understand that the potential complications from routine treatment include, but are not limited to allergic reaction, drug reaction, pain, swelling, bruising, temporary or limited opening, temporary or permanent numbness, temporary or permanent mouth problems and infection. I consent to have exams, radiographs, cleanings, models, photographs and other diagnostic aids/tests preformed at Rocky Mountain Dental Arts.

I understand that it is my responsibility to inform the dentist of changes in my medical history and medications prior to treatment. Occasionally, unforeseen conditions or circumstances may arise during the course of treatment. Therefore, additional treatment may be necessary or advisable as a result of any unforeseen events, conditions or circumstances. I understand that any treatment plans presented, along with the fees outlined, could change depending on the time elapsed since the initial examination and extent of dental pathology. The staff at Rocky Mountain Dental Arts will always discuss these changes in treatment and cost, and I will have the ability to ask questions.

I have read all of the conditions of the Financial Agreement and Office Protocols, HIPPA Information-Notice of Privacy Practices, and Consent for Treatment and have accurately provided our office with current and updated information including but not limited to insurance coverage information

Print Name: _____ Date:____/____/_____

Signature: _____

Health History

Name:_____ Date of Birth: ____/____/_____

Height:_____ Weight_____ Gender: Male Female

Primary Care Physician: _____ Phone Number:_____

Are you currently under the care of a physician? Yes No If yes, please describe: _____

_____

Have there been any major changes in your health the past year? Yes No If yes, please describe:_____

_____

Have you ever had a serious illness, surgery, or hospitalization? Yes No If yes, please describe and provide dates:_____

Do you have or had you have any of the following? (Please circle and describe below)

Arthritis	Anemia	Artificial Joints	Asthma/Emphysema
Angina	Arteriosclerosis	Autoimmune Disease	Artificial Heart Valves
Blood Disease	Bone Disease	Bleeding Disorder	High Blood Pressure
Low Blood Pressure	Bronchitis	Congestive Heart Failure	Cancer
Chemotherapy	Chronic Pain	Congenital Heart Defect	Diabetes: Type I or II
Eating Disorder	Epilepsy	Fainting	Gastrointestinal Disease
GERD/Acid Reflux	Glaucoma	Headaches/Migraines	Heart Disease
Hepatitis/Jaundice	Herpes Virus	Heart Murmur	Heart Attack
Infectious diseases (HIV, AIDS etc)		Kidney Disease	Lung Disease/COPD
Liver Disease	Lymphoma	Mental Health Disorder (Anxiety, depression, bipolar etc)	
Mitral Valve Prolapse	Neurologic Disorder	Osteoporosis	Osteopenia
Pacemaker	Rheumatoid Arthritis	Rheumatic Fever	Radiation Treatment
Sleep Apnea/Snoring	Seasonal Allergies	Stroke/TIA	Sinus Issues
Sexually Transmitted Disease		Thyroid Disease	TMJ/Jaw joint Pain
Tuberculous	Ulcers/Colitis		

Other:_____

Details on any conditions circled above:_____

_____

_____

Do you smoke or use tobacco products? Yes No Smoke Chew Frequency:_____

Do you use Marijuana? Yes No Smoke Edibles Other Frequency:_____

Do you currently use of have a history of using control substances (drugs): Yes No Type:_____

Do you use Alcohol? Yes No Frequency:_____

Women Only: Are you pregnant or is there chance you might be pregnant? Yes No Due Date:_____

Are you currently nursing? Yes No Are you on birth control? Yes No

List any *allergies or sensitivities* to medications or other substances:_____

_____

List all medications, supplements, vitamins, herbal remedies, alternative medicines or over the counter drugs you are currently taking: _____

_____

_____

Have you ever taken bisphosphonate or anti-resportive agent (ie: Fosamax. Boniva, Reclast, Prolia, Zometa, Xgeva)? Yes No If yes, was it oral or IV? Oral IV

Which Medication and how long did you take the medication? _____

Dental History

Date of last dental visit:_____ Date of last dental x-rays:_____

Name and location of previous dentist:_____

Have you had any recent changes in your oral health? Yes No If yes, please describe:_____

_____

Have you ever been prescribed antibiotics prior to dental procedures? Yes No If yes, name medication and reason for taking:_____

What are your main dental concerns?:_____

Are you currently experiencing any dental pain or discomfort?:_____

Do you have or had you have any of the following? (Please circle and describe below):

Braces/Orthodontic Treatment Periodontal or Gum Disease Periodontal Surgery (ie: grafting)

Extensive Oral Surgery Injury to the mouth or face Sensitivity to cold, hot or sweets

Frequent sores or ulcers in your mouth Clenching or grinding Dry mouth

Persistent jaw pain, clicking or popping Tooth pain with eating/chewing

Bleeding gums when brush or floss Biopsy of area in mouth

Other or please describe:_____

_____

Is there anything you do not like about your smile or anything you want to change?_____

_____

On a scale of 1-10 how apprehensive are you about dental treatment?_____

Is there anything else you want us to know about your dental health?_____

_____

The information I have provided is accurate to the best of my knowledge. I hereby consent Rocky Mountain Dental Arts PC use of my personal information, dental and health information for the purposes of treatment, payment and/or health care operations. I understand that this information serves as the basis for planing my care and treatment, a means of communication about my healthcare professionals and facilities that contribute to my care, as a means by which third party(s) identify that services were provided, and as a means by which Rocky Mountain Dental Arts PC can contact me regarding my dental care and appointments through a third party communication service.

Signature:_____ Date: ____/____/_____