spring creek dental PLLC
DRS. KAINES & COSPER

JOEL KAINES, DDS
LINDSEY COSPER, DDS

WWW.MYDENTISTFORTCOLLINS.COM
Tel: (970) 482-8883

2001 S. SHIELDS ST. BLDG C1
FORT COLLINS, CO 80526

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐OTHER ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:
ADDRESS LINE 1
CITY ST ZIP CODE

HOME:
CELL:
WORK:

E-Mail:

How did you hear about our office?

EMPLOYMENT INFORMATION

Employer: Occupation:

INSURANCE INFORMATION

Subscriber:
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:
CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:
CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: Treatment Type:

☐Y☐N Are you currently having dental discomfort? If yes, explain:
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain:
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain:
☐Y☐N Are your teeth sensitive to cold, hot, sweets, or pressure?
☐Y☐N Orthodontic appliances (braces) now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Is your mouth dry?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you have any clicking, popping, or discomfort in the jaw?
☐Y☐N Do you have sores or ulcers in your mouth?

What is the reason for your dental visit today?

Is there anything you would like to change about your smile?

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PATIENT INFORMATION

Patient Name: _____
LAST FIRST MI PREFERRED TITLE

Date of Birth: _____

Your mouth is an important part of your entire body. Health problems that you may have elsewhere in your body, or medications that you take, could have an important interrelationship with the dentistry you will receive. Thank you for taking time to answer the questions below.

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____ City/State/Zip: _____

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now? _____
☐Y☐N Any serious illnesses/surgeries/hospitalizations? _____
☐Y☐N Use tobacco in any form? If Yes, Type: _____
☐Y☐N Do you drink alcoholic beverages? _____
☐Y☐N Are you on any special diet? _____
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint (hip, knee, shoulder)? Date: _____
☐Y☐N Are you taking, or have taken, any diet drugs such as Pondimin, Redux, or fen-phen?

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

- Are you taking/have you ever taken/are you scheduled to begin taking alendronate (Fosamax), risendronate (Actonel), ibandronate (Boniva) or any other bisphosphonate medication for osteoporosis or Paget's disease? ☐Y☐N
  If yes, please explain: _____
- Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? ☐Y☐N
  Date Treatment Began: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING AND IF YES PLEASE EXPLAIN? (CHECK ALL THAT APPLY): ☐NONE

☐ ACID REFLUX/HEARTBURN
☐ AIDS/HIV
☐ ALZHEIMER'S DISEASE
☐ ANEMIA
☐ ANGINA
☐ ANOREXIA/BULIMIA
☐ ANXIETY
☐ ARTERIOSCLEROSIS
☐ ARTIFICIAL HEART VALVE
☐ ARTHRITIS
☐ ASTHMA
☐ AUTOIMMUNE DISEASE
☐ BLEEDING DISORDER/HEMOPHILIA
☐ BLOOD DISEASE
☐ BLOOD TRANSFUSION YEAR:___
☐ BREATHING PROBLEMS
☐ BRONCHITIS
☐ BRUISE EASILY
☐ CANCER/MALIGNANCY
☐ CARDIOVASCULAR DISEASE
☐ CHRONIC COUGH
☐ CHRONIC PAIN
☐ COLD SORES/FEVER BLISTERS
☐ CONGENITAL HEART DISORDER
☐ CONGESTIVE HEART FAILURE
☐ DAMAGED HEART VALVES
☐ DIABETES TYPE:_____
☐ DIZZINESS/FAINTING
☐ DRUG/ALCOHOL ADDICTION
☐ EMPHYSEMA
☐ EPILEPSY/SEIZURES
☐ EXCESSIVE URINATION
☐ GASTROINTESTINAL DISEASE
☐ GLAUCOMA
☐ HAY FEVER/SEASONAL ALLERGIES
☐ HEART ATTACK
☐ HEART DISEASE
☐ HEART MURMUR
☐ HEPATITIS
☐ HERPES
☐ HIGH CHOLESTEROL
☐ HIVES/RASH
☐ HYPOGLYCEMIA
☐ IRREGULAR HEARTBEAT
☐ JAUNDICE
☐ KIDNEY PROBLEMS
☐ LIVER PROBLEMS
☐ LOW BLOOD PRESSURE
☐ LUNG DISEASE
☐ MIGRAINES/FREQUENT HEADACHES
☐ MITRAL VALVE PROLAPSE
☐ MONONUCLEOSIS
☐ OSTEOPOROSIS
☐ PACEMAKER
☐ PAIN IN JAW JOINTS
☐ PARATHYROID DISEASE
☐ PERSISTENT SWOLLEN GLAND-NECK
☐ PSYCHIATRIC TREATMENT
☐ RADIATION
☐ RENAL DIALYSIS
☐ RESPIRATORY DISEASE
☐ RHEUMATIC HEART DISEASE
☐ RHEUMATIC FEVER
☐ RHEUMATOID ARTHRITIS
☐ SHINGLES
☐ SICKLE CELL DISEASE
☐ SINUS PROBLEMS
☐ SLEEP DISORDERS
☐ STOMACH/INTESTINAL DISEASE
☐ STROKE
☐ SWELLING OF LIMBS
☐ SYSTEMIC LUPUS ERYTHEMATOSUS
☐ THYROID CONDITION
☐ TONSILLITIS
☐ TUBERCULOSIS
☐ TUMORS/GROWTHS
☐ ULCERS
☐ WEIGHT LOSS (RAPID)
☐ OTHER: PLEASE LIST:
_____
_____
_____
_____
_____

IF DIABETIC, LAST A1C: _____
AND LEVEL OF CONTROL: _____

IF EPILEPSY/SEIZURES,
TRIGGERS/FREQUENCY:
_____

IF HIGH BLOOD PRESSURE,
LEVEL OF CONTROL: _____

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IF ANY CONDITIONS OR ALERTS SELECTED IN THE PREVIOUS PAGE NEED FURTHER CLARIFICATION, PLEASE DESCRIBE BELOW:

_____
_____
_____
_____
_____
_____

ALL PATIENTS: ARE YOU ALLERGIC /CANNOT TAKE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ACRYLIC
☐ ASPIRIN/IBUPROFEN
☐ ANESTHETIC - LOCAL
☐ BARBITURATES
☐ CODEINE
☐ DAIRY
☐ LATEX
☐ OTHER – PLEASE LIST:
☐ FOOD
☐ METAL SENSITIVITY
☐ IODINE
☐ ANIMALS
☐ SULFA DRUGS
☐ PENICILLIN

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS
☐ BLOOD THINNERS
☐ INSULIN
☐ OTHER DIABETIC MEDICATIONS
☐ OTHER (PLEASE LIST BELOW)
☐ ANTIHISTAMINES/ALLERGY
☐ CANCER/CHEMO MEDICATIONS
☐ NITROGLYCERIN
☐ RECREATIONAL DRUGS
☐ DAILY ASPIRIN
☐ CORTISONE/STEROIDS
☐ ORAL CONTRACEPTIVES
☐ THYROID MEDICATIONS
☐ BLOOD PRESSURE MEDICATIONS
☐ HEART MEDICATION/DIGITALIS
☐ OSTEOPOROSIS MEDICATIONS
☐ TRANQUILIZERS

MEDICATION/SUPPLEMENT NAME	DOSAGE	REASON PRESCRIBED

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 my medical status.

Patient Name: _____

Signature of Patient of Guardian:_____ Date:_____

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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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 in social interactions 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 allergic or sensitivity reactions.
2. **Long-term Numbness (par aesthesia).** Local anesthetic, or its administration, while almost always adequate to follow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or Joint Tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or jaw tenderness or in a predisposed patient precipitate a TMJ disorder.
4. **Sensitivity in Teeth or Gums, Infection, or Bleeding.**
5. **Swallowing or Inhaling Small Objects.**

While we follow procedural guidelines that most often lead to 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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Office Payment Policy

In order to control costs, **payment is required at the time that services are performed.** Since we do not carry account balances past 30 days, we offer Care Credit (interest free credit company we partner with) and we also accept all major credit cards including Visa, Discover, Master Card, and American Express.

Your insurance contract is made between you and your insurance company. Insurance policies often do not cover 100% of the billed amount for dental procedures. Insurance companies have their own fee schedules in which their payment is based upon. Payment of your account is your responsibility.

As a courtesy, we will file on all insurance companies for you. Every effort is made to get an accurate estimate from your insurance company prior to your appointment and our front office staff will always give you a copy of your estimated portion prior to scheduling. We ask that you pay your portion whether it is for a cleaning or for restorative work at the time of service. If there is a difference after your insurance pays their portion, we will either send you a statement or a refund.

Account balances left over 90 days will be turned over to a collection agency. Patient agrees to pay all court costs and fees associated with collection. Returned checks will be charged a $50 fee.

If you have any questions regarding your treatment or payment options please call us during our business hours.

As a courtesy to our other patients, we require 48 hours or 2 business days' notice for the cancellation of any appointment so that we may offer that appointment to another patient. A fee of $50 per hour of time may be assessed to your account if sufficient notice is not given.

_____ _____

Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

Print Name Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and acknowledgement could not be obtained because:

- — Individual refused to sign
- — Communication barriers prohibited obtaining the acknowledgement
- — An emergency situation prevented us from obtaining acknowledgment
- — Other (please specify)

I authorize the following person(s) below to have full access to my dental records:

Name and Address:

_____ _____

Signature Date