Shawn R. Harvey DDS, PLLC
PO BOX 2085
Crested butte, CO 81224
~phone: 970-349-5731 ~fax: 970-349-0562 ~email: Shawnharveydentistry@gmail.com

Patient Information

Are you related to any current patients? If so who?_____Combine accounts? Y/N

First Name_____Middle Initial_____Last Name_____Preferred Name_____

Date_____ Gender: male/female Family Status: married/single/child/other

Birth Date_____ SSN_____

Mailing Address, City, State, Zip _____

Email Address_____

Home Phone_____Cell Phone_____Other Phone_____

Emergency Contact Name _____Phone_____

Insurance Information -please complete OR provide card

Name of Insured_____Relationship: self/spouse/child/other

Birthdate_____SSN#/SIN_____

Insurance Company_____

Insurance Address_____

Employer_____

Group #_____Policy ID #_____Phone _____

How Did You Hear About Us?

(circle one)

Internet Phone Book Newspaper Friend_____ Other_____

Insurance Agreement

_____I understand and agree that dental policies are a contract between my insurance company and
initial myself. I also understand that if my insurance provider refuses payment or my services are not billable to insurance or my deductible has not been met, I am directly and fully responsible to pay the full amount to Dr. Harvey directly within 30 days of this determination. We do not discount for unpaid insurance. I also understand that verification of benefits prior to services rendered is my responsibility and some services may not be covered by my individual insurance policy. Payment for these services are fully my responsibility.

Missed Appointments

_____Please contact our office at least 48 business hours prior to your appointment if you need to
initial reschedule or cancel an appointment for any reason. Failure to do this will result in a $55.00 missed appointment fee.

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Patient Medical Information

Do you have or had a history of the following:

Yes No Have you been hospitalized in the last year (for_____)
Yes No Do you have any artificial joints (type/when_____)
Yes No Have you had orthopedic surgery in the last year (type/when_____)
Yes No High cholesterol or taking statin drugs
Yes No High blood pressure
Yes No Low blood pressure
Yes No Had a stroke or taking blood thinners
Yes No History of infective endocarditis
Yes No Artificial heart valve, repaired heart defect (PFO), heart condition or cardiac stent in the last 6 months, pacemaker or implantable defibrillator
Yes No Heart murmur , scarlet fever or Rheumatic fever
Yes No Diabetes
Yes No AIDS/HIV
Yes No Human Papilloma Virus (HPV)
Yes No Hepatitis (type_____)
Yes No Anemia or any blood disease
Yes No Cancer/Chemotherapy or Radiation treatment
Yes No Epilepsy/ Seizures
Yes No Ulcers
Yes No Head or neck injuries
Yes No Digestive disorders (i.e. gastric reflux)
Yes No Osteoporosis/osteopenia (i.e. taking or have taken bisphosphonates)
Yes No Thyroid condition
Yes No Kidney disease or Liver disease
Yes No Asthma
Yes No Respiratory disease
Yes No Tuberculosis
Yes No Sinus problems
Yes No Do you experience frequent headaches
Yes No Glaucoma
Yes No Contact lenses
Yes No Psychiatric or emotional problems
Yes No Chronic nervousness
Yes No A smoking habit
Yes No Have/had a smokeless tobacco habit
Yes No Do you drink alcohol? How many drinks a day_____week_____
Yes No Have you used any recreational drugs in the last 24hrs
Yes No Allergy to Latex
Yes No FEMALE: Pregnant or nursing
Yes No FEMALE: Taking birth control

List any allergies:
(medical/environmental/seasonal/food):_____
If no Allergies initial here _____
List any prescription and over-the-counter medications or supplements you are currently taking: ___
_____
_____

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Patient Dental History:

Reason for visit_____

Do you have or had a history of the following:

Yes	No	Sensitive to hot, cold or sweets
Yes	No	Sensitive to biting
Yes	No	Any broken or loose teeth
Yes	No	Do you frequently get food caught between any teeth
Yes	No	Any problems with your jaw joint (limited opening, locking, sore muscles)
Yes	No	Do you wear or have your worn a bite appliance
Yes	No	Have your teeth become shorter, thinner or worn in the last five years
Yes	No	Do you grind or clench your teeth or has anyone told you that you do
Yes	No	Have you ever had orthodontic treatment
Yes	No	Do you have any breathing or sleeping problems
Yes	No	Do you ever experience dry mouth
Yes	No	Any lumps or swelling on your lips, gums or tongue
Yes	No	Any cold sores or canker sores
Yes	No	Are you fearful of dental treatment? If so how much on a scale of 1-10 _____
Yes	No	Have you ever had trouble getting numb
Yes	No	Have you ever had an adverse reaction to local anesthetic
Yes	No	Do you avoid brushing any part of your mouth
Yes	No	Do your gums bleed or are they painful when brushing or flossing
Yes	No	Have you ever been treated for gum disease
Yes	No	Is there anyone with a history of gum disease in your family
Yes	No	Do you have any gum recession or bone loss around your teeth
Yes	No	Would you be interested in whitening your teeth
Yes	No	Anything about the appearance or function of your teeth you would like to change Please explain: _____ _____

Former Dentist Information

Former dentist_____ Contact_____ Can we contact them for notes and x-rays? __

Date of last dental visit_____Date of last dental x-rays_____

Signature of patient, parent or guardian (responsible party):

Signature: _____ Date: _____

Dr. Signature_____ Date: _____

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance of treatment.

A service charge of 1% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay for the services at the time of treatment, or within (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be intuited hereunder.

_____ I have read the above conditions of treatment and payment and agree to their content.
(**initial**)

_____I grant permission to you and your assignee to telephone me to discuss this statement or (**initial**) my treatment.

_____ I have been informed of HIPAA Privacy Practices.
(**initial**)

Signature of patient, parent or guardian (responsible party):

Signature: _____ Date: _____

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Date: _____

Dr._____

Phone:_____

Fax: _____

I, _____ , DOB _____ request my dental records be sent to:

Dr. Harvey
shawnharveydentistry@gmail.com
P.O. Box 2085
Crested Butte, CO. 81224

For the following family members:

_____
_____
_____
_____

Comments:

_____
Patient or guardian signature