The Conifer Dental Group WELCOMES YOU

Please take a few minutes to complete this form and your patient health record. It is very important that all questions be answered in as much detail as possible. This information is confidential and please ask for assistance if you need clarification.

Patient Name _____
Last First Middle

How do you wish to be addressed? _____

Whom may we thank for referring you to our office? _____

If you found our office in a manner other than by personal recommendation please check the appropriate box: ☐ Sign/Location ☐ Yellow Pages ☐ Newspaper ☐ Our CDG website

Home Address _____
Street City State Zip

Telephone _____
Home Cell Work

Employer _____ Occupation _____

Work Address _____
Street City State Zip

Birthdate _____ Social Security # _____ Email: _____

☐ Female ☐ Male ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

---------- BUSINESS INFORMATION ----------

Who is responsible for this account? _____ Birthdate _____

Driver's License # _____ Social Security # _____

Relationship to patient? ☐ Self ☐ Mother ☐ Father ☐ Wife ☐ Husband ☐ Guardian ☐ Foster

Dental Insurance Company _____ Telephone # _____

ID # _____ Group # _____

Policy Holder's Employer _____ Telephone # _____

Does your Employer provide a flex spending account? ☐ Y ☐ N

Dental Insurance Deductible Amount? $_____ Has it been met this year? ☐ Yes ☐ No

(over)

The Conifer Dental Group
MEDICAL HISTORY

Quality dental care requires a thorough understanding of your past and current medical situation. Please complete this form by checking the appropriate box to the right of each question and check off any condition that may be applicable.

Patient's Name _____
Last First Middle Date of Birth

Physician's Name _____ Primary Care ☐ Y ☐ N

Address _____ Telephone # _____

Please rate your general health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please Explain

Are you under a physician's care now? ☐ Y ☐ N
For what period of time? _____
For what condition? _____
When was your last physical examination? _____
Have you been hospitalized? ☐ Y ☐ N
For what condition? _____ When? _____
Do you anticipate making any changes aimed at improving your health? ☐ Y ☐ N
Please explain _____
_____
Have you had any operations? _____ ☐ Y ☐ N
Are you taking any medication or drugs presently? ☐ Y ☐ N
Please list _____
Have you had serious injury to your head or neck? ☐ Y ☐ N
Do you smoke or use tobacco? ☐ Y ☐ N
What? _____ How often? _____
Are you allergic or have reacted adversely to any medications? ☐ Y ☐ N
☐ Aspirin ☐ Tylenol ☐ Advil ☐ Codeine ☐ Morphine
☐ Penicillin ☐ Sulfa ☐ Erythromycin ☐ Other antibiotics
☐ Local anesthetics (Novocaine) ☐ IV anesthetics
Are you sensitive to any metals, foods, or other substances? ☐ Y ☐ N
☐ Gold ☐ Silver ☐ Tin ☐ Palladium ☐ Titanium ☐ Platinum
☐ Latex ☐ Acrylic ☐ Plastic ☐ Shellfish ☐ Other foods _____
Have you been told you have or been treated for heart disease? ☐ Angina ☐ Y ☐ N
☐ High blood pressure ☐ Heart attack ☐ Mitral valve prolapse ☐ Bypass
☐ Rheumatic fever ☐ Heart murmur ☐ Pacemaker ☐ Valve implant ☐ Stint
Do you have any blood related problems or diseases? ☐ Y ☐ N
☐ Anemia ☐ Hemophilia ☐ Sickle cell disease ☐ Leukemia ☐ Transfusion
☐ Malignant hypothermia ☐ Abnormal bleeding ☐ Abnormal clotting
Do you have artificial joints/prosthesis? Placed when? _____ ☐ Y ☐ N
Do you have inflammatory or autoimmune diseases? ☐ Y ☐ N
☐ Arthritis ☐ Rheumatoid ☐ Fibromyalgia ☐ Lupus ☐ Sjorgens syndrome
Do you or have you taken medications (Fosomax) to prevent calcium loss? ☐ Y ☐ N
Are you diabetic? ☐ Juvenile? ☐ Adult Onset? ☐ Y ☐ N
Do you have stomach problems? ☐ Acid Reflux ☐ Hiatal hernia ☐ Ulcer ☐ Y ☐ N
Do you have liver problems? ☐ Hepatitis ☐ A ☐ B ☐ C ☐ Y ☐ N
Do you have kidney problems? ☐ Y ☐ N
Do you have lung disease? ☐ Tuberculosis ☐ Asthma ☐ Emphysema ☐ COPD ☐ Y ☐ N
Do you have thyroid disease? ☐ Hypothyroid ☐ Hyperthyroid ☐ Graves ☐ Y ☐ N
Do you have eye problems? ☐ Glaucoma ☐ Dry Eye Syndrome ☐ Contact Lenses ☐ Y ☐ N

Have you ever been treated for cancer or a tumor? ☐ Y ☐ N

☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Biophosphonate

Do you have or have you been treated for neurological difficulties? ☐ Y ☐ N

☐ Fainting ☐ Seizure ☐ Epilepsy ☐ Stroke ☐ Multiple Sclerosis

☐ Alzheimer's

Have you had or are you currently receiving psychological treatment? ☐ Y ☐ N

Do you have or have you had a sexually transmitted disease? ☐ Y ☐ N

Have you tested HIV positive? ☐ Y ☐ N

Do you have AIDS? ☐ Y ☐ N

Do you regularly consume alcoholic beverages? How much? _____ ☐ Y ☐ N

Are you a recovering alcoholic? ☐ Y ☐ N

Do you habitually use controlled substances? ☐ Y ☐ N

Please Explain

WOMEN

Are you or do you expect to get pregnant? ☐ Y ☐ N

Are you using birth control medications? ☐ Y ☐ N

Are you using hormone replacement drugs? ☐ Y ☐ N

Are you nursing? ☐ Y ☐ N

Do you have any disease condition or problem not listed above?

If so please explain._____

_____

Is there anything else about your health that has not been covered on this form?

_____

_____

Would you like to speak to the Doctor privately about any problem? ☐ Y ☐ N

I certify that all of the preceding answers are correct. If I have any changes to my health status or medications, I will inform the dentist and staff at my next appointment.

_____ _____

Patient's Signature Date Doctor's Signature Date

MEDICAL HISTORY UPDATES

Date	Change in Medical Situation and/or Medication	Patient Signature	Clinician Signature

(over)

---------- EMERGENCY NOTIFICATION INFORMATION ----------

Nearest relative not living with you? _____

Relationship _____ Telephone _____
Home Cell Work

Address _____
Street City State Zip

------ TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT ------

I consent to treatment as necessary or desirable for the care of the patient first named on the front of this form. This authorization provides for the utilization of procedures necessary for the diagnosis and treatment of dental disease, deformity, and dental emergency. These procedures may include (and not be limited to) intraoral and extraoral examinations, radiographs, dental casts and photographs. I give my consent to the use of local anesthetics for pain relief during treatment and understand that the practice of dentistry involves the responses of living tissues and a perfect result cannot be guaranteed.

I authorize the utilization and transfer (including electronic) of my photographs and dental records to doctors, dental laboratory technicians, students and patients for the benefit of treatment and education.

In the case of dental emergency, I consent to treatment as deemed necessary by the Doctor for myself and/or my child, understanding that the procedures will be explained in advance if I am available and conscious. If I am not available or conscious I authorize the Doctor to provide emergency treatment for me and my family as deemed appropriate by the Doctor.

I grant the Conifer Dental Group the right to release my dental and medical treatment histories and other information to third party payers and/or other health professionals.

I acknowledge full responsibility for the payment of services and agree to pay for them, in full, at the time of service, unless other arrangements are made in advance. To avoid a misunderstanding regarding dental insurance, all professional services rendered are charged directly to the patient and patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain insurance benefits upon receipt of payment of fees. We do not render services on the basis that insurance companies will pay all fees.

I understand SERVICE CHARGES will be applied to any unpaid balances incurred by my family and me at a periodic rate of 1.5% per month even if they are subject to payment by insurance companies. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorneys fees incurred in the collection of the account.

_____ _____
Signature (Parent or Guardian if Patient is a Minor) Date

The Conifer Dental Group
DENTAL HISTORY

Quality care requires a thorough understanding of your past and current dental situation. Please complete this form by checking the appropriate box to the right of each question and check off any condition that may be applicable.

Patient's Name _____
Last First Middle Date of Birth

Please rate your general health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

When was your last dental visit? _____

Previous dentist's name? _____

City? _____ Telephone # _____

When was your last full mouth (18 films) or panoramic X-ray? _____

Please Explain

Are you in discomfort requiring our immediate dental attention?	☐ Y ☐ N
Describe _____	
Have you had regular dental checkups in the past three years?	☐ Y ☐ N
Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure	☐ Y ☐ N
Do you have any pain in any part of your mouth while biting?	☐ Y ☐ N
Do you chew on both sides of your mouth?	☐ Y ☐ N
Do your gums bleed while brushing, flossing, or chewing?	☐ Y ☐ N
Do your gums feel irritated, tender or swollen?	☐ Y ☐ N
How many times per day do you brush your teeth? _____	
Do you avoid brushing any part of your mouth?	☐ Y ☐ N
Do you use supplemental tooth cleansing aids?	☐ Y ☐ N
☐ Mechanical toothbrush ☐ Waterpick ☐ Floss ☐ Toothpick	
What toothpaste or dentifrice do you use? _____	
Have you had professional instructions about dental home care?	☐ Y ☐ N
Have you ever had any type of gum treatment (periodontal) or surgery?	☐ Y ☐ N
Are you bothered by bad breath?	☐ Y ☐ N
Do you have any loose teeth? Where? _____	☐ Y ☐ N
Have you lost any teeth in the past?	☐ Y ☐ N
Why? _____	
Have they been replaced?	☐ Y ☐ N
Would you like to save your remaining teeth?	☐ Y ☐ N
Do you have unhealed sores or swollen areas in your mouth?	☐ Y ☐ N
Do you have reduced salivary flow or dry mouth?	☐ Y ☐ N
Do you get cold sores or canker sores?	☐ Y ☐ N
Are you bothered by food getting stuck between your teeth?	☐ Y ☐ N
Do your teeth or fillings fracture or chip?	☐ Y ☐ N
Do you clench or grind your teeth during the day?	☐ Y ☐ N
Have you been made aware of grinding during the night?	☐ Y ☐ N
Do you wake in the morning with a headache?	☐ Y ☐ N
Do your jaw joints pop, click, or lock?	☐ Y ☐ N
Do you have pain or ringing in your ears?	☐ Y ☐ N
Do you ever have pain or soreness in the muscles of your face?	☐ Y ☐ N
Are headaches, shoulder aches or neckaches something you deal with frequently?	☐ Y ☐ N
Are you familiar with the dental term "traumatic occlusion"?	☐ Y ☐ N
Are you pleased with the appearance of your teeth and smile?	☐ Y ☐ N
Why? _____	
Why not? _____	
Have you had unpleasant dental experiences in the past?	☐ Y ☐ N
Which of the following would help make your visit more enjoyable?	
☐ Nitrous Oxide ☐ Headphones/Music/Video ☐ Support Pillow	

To the best of my knowledge, all of the preceding answers are true and correct.

Patient's Signature Date Doctor's Signature Date

Conifer Dental Group
10801 Kitty Drive Conifer CO 80433
303-838-7904

Please help us to update our records. We are trying to identify our patients' potential risk for diabetes and the possibility of having sleep apnea. Please answer the following questions.

Type II Diabetes Assessment	Yes	No
1. Do you have Heart Disease or High Blood Pressure?	____	____
2. Have you experienced sudden, unexplained weight loss?	____	____
3. Do you suffer from frequent thirst and urination?	____	____
4. Have you experienced increased appetite?	____	____
5. Have you suffered from ongoing fatigue?	____	____
6. Have you had blurred vision?	____	____
7. Have you experienced recurring skin or periodontal (gum) infections?	____	____
8. Do you have a sedentary lifestyle?	____	____
9. Do you have any family members with diabetes?		
10. If yes, who? _____		

Sleep Apnea Assessment	Yes	No
1. Do you snore or have you been told you snore?	____	____
2. Are you ever tired during the day?	____	____
3. Do you ever wake up with headaches in the morning?	____	____
4. Have you been told you gasp for air or awaken suddenly in your sleep?	____	____
5. Have you been told to wear CPAP or do you wear CPAP?	____	____
6. Have you been asked to or have you taken a sleep study?	____	____

Signature_____**Date**_____

Thank you for your time. Dr. Wilson

J. DOUGLAS WILSON
CONIFER DENTAL GROUP
10801 KITTY DRIVE, CONIFER, CO 80433
303-838-7904

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth: _____
Email Address (PLEASE PRINT CLEARLY): _____

I agree that the dental practice may communicate with me electronically at the email address above. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling 303-838-7904. **PATIENT INITIALS** _____

Cancellation Policy

We take our patients' care very seriously and want to ensure that we can offer appointments to our patients in a timely manner. When patients cancel or reschedule at the last minute those available time slots often remain unfilled. If we receive appropriate notice of cancellation, we can then offer those time slots to another patient in need of our dental care that has to wait to be seen.
Our cancellation policy is as follows:
Office Visits- Please arrive at least 5 minutes prior to your scheduled appointment time. Our Front Desk will check you in update any changes to your insurance or contact information. If you are a new patient, please bring your completed paperwork with you or arrive 15 minutes prior to your appointment. If you arrive late your appointment, you may be asked to reschedule in consideration of those who have arrived on time and are waiting to see one of the providers. **You must cancel or reschedule your office visit appointment 24 hours prior to your appointment or you will be assessed a $50.00 fee. No-shows-Reschedules- If you continuously no show your appointments or repeatedly reschedule, you may be dismissed from the practice.** After three occurrences, your account will be reviewed by your Provider and a determination will be made.
I have read and understand the cancellation policy for Conifer Dental Group. **PATIENT INITIALS** _____

COVID-19 Pandemic

1. I knowingly and willingly consent to dental treatment at Conifer Dental Group by Dr. Wilson and any designated associates and employees during the COVID-19 pandemic.
2. I understand that the Conifer Dental Group and Dr. Wilson are following CDC guidelines.
3. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has it and who does not given the current limitations and availability in COVID-19 viral testing. I understand that dental procedures create aerosol (water spray) which is one way the disease is spread. The ultra-fine nature of the spray may linger in the air for hours, which may transmit the COVID-19 virus.
4. Risk of transmission: I understand that due to the frequency of visits, of other dental patients, characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though mandates are being observed.
5. **I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19: Fever of 100.0 degrees F, Shortness of breath, Dry cough, Reduced sense of taste/smell, Sore throat, Runny nose.**
6. Contact with infected: I confirm that I have not knowingly been in close contact defined as 6 feet or less for a duration of fifteen minutes or more with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in the last 14 days.
7. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and I have been given the opportunity to ask questions.
PATIENT INITIALS _____

Patient/Guardian Name: _____ Date: _____

Patient Signature: _____