Dr. Loper Dentist

Office: 303.794.3969
Fax: 303.794.4784
www.drloperdentist.com
info@drloperdentist.com
1279 W. Littleton Blvd.
Littleton, CO 80120

# WELCOME

## PATIENT INFORMATION

DATE:_____

PATIENT NAME:_____ Male / Female

PREFERRED NAME:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

EMAIL:_____ **REFERRED BY:**_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL:_____

I would like to receive appointment reminders (please circle): email text message phone

Status (please circle): Married Single Divorced Widowed Child

For child or teenager, please list:

PARENT'S NAME:_____ PHONE:_____

PARENT'S NAME:_____ PHONE:_____

## RESPONSIBLE PARTY FOR ACCOUNT

NAME:_____ MARITAL STATUS:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL:_____

SOCIAL SECURITY NUMBER:_____ RELATIONSHIP TO PATIENT:_____

## EMPLOYMENT INFORMATION

EMPLOYER NAME:_____ OCCUPATION:_____

## DENTAL INSURANCE INFORMATION

**PRIMARY**

POLICY HOLDER:_____ INSURANCE COMPANY:_____

POLICY HOLDER BIRTH DATE:_____ SS#/ID#:_____

POLICY HOLDER EMPLOYER:_____ GROUP NUMBER:_____

POLICY HOLDER PLAN NAME:_____ PHONE NUMBER:_____

**SECONDARY**

POLICY HOLDER:_____ INSURANCE COMPANY:_____

POLICY HOLDER BIRTH DATE:_____ SS#/ID#:_____

POLICY HOLDER EMPLOYER:_____ GROUP NUMBER:_____

POLICY HOLDER PLAN NAME:_____ PHONE NUMBER:_____

## EMERGENCY CONTACT INFORMATION

NAME:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL:_____

Dr. Loper
Dentist

# MEDICAL - DENTAL HISTORY

PATIENT NAME:_____

DATE OF BIRTH:_____

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## PATIENT MEDICAL HISTORY

Pharmacy Name:_____

Pharmacy Phone:_____

□YES □NO Are you under any medical treatment now?
If so, please list:_____

□YES □NO Have you had any surgeries in the past 5 years?

_____

□YES □NO Have you had any recent joint replacements?

□YES □NO Have you been told you need to pre-med?

□YES □NO Ever had a serious accident involving head or jaw injuries?

Have you ever had any of the following?

- □ Heart Disease
- □ Heart Murmur
- □ Mitral Valve Prolapse
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Respiratory Disease
- □ Diabetes
- □ Rheumatic Fever
- □ Arthritis
- □ Stroke
- □ Multiple Sclerosis
- □ Tumors or Growths
- □ Any Blood Disease
- □ Any Liver Disease
- □ Any Thyroid Disease
- □ Any Kidney Disease
- □ Any Stomach or Intestinal Disease
- □ Any Venereal Disease
- □ Yellow Jaundice or Hepatitis
- □ Epilepsy
- □ AIDS/HIV
- □ Other:_____

□YES □NO Are you **allergic** to any known materials or medications resulting in hives, asthma, eczema, etc?

(Please list)_____

_____

□YES □NO Do you have a latex allergy?

□YES □NO Do you have any reason to suspect you are ***not*** in good health?

□YES □NO Have any wounds healed slowly or presented other complications?

□YES □NO Are you pregnant? If so, when is your due date?_____

□YES □NO Have you ever had Chemotherapy/Radiation? When?, Where? _____

□YES □NO Have you ever had any head and neck Radiation Treatment?

□YES □NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker? _____

□YES □NO Are you currently using tobacco products?

□YES □NO Are you now taking prescription drugs, medications or blood thinners?

□YES □NO Are you taking bisphosphonate drugs?(i.e. Fosamax, Zometa,Actenol)

□YES □NO Are you currently taking any Immune Suppressant Drugs?

**Please list all current medication including over the counter.**

| Current Medication | Reason |
|---|---|
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## PATIENT DENTAL HISTORY

Date of last dental visit:_____

When was your last Full Mouth Series of x-rays taken?
When?_____Where?_____

□YES □NO Do you have any specific problems?

□YES □NO Do you have pain in or near your ears?

□YES □NO Any unhealed injuries or inflamed area in or around your mouth?

□YES □NO Have you experienced any growth or sore spots in your mouth?

□YES □NO Any reactions or allergic symptoms to local anesthetic?

□YES □NO Any difficult extractions in the past?

□YES □NO Have you had prolonged bleeding following extractions in the past?

□YES □NO Do your gums bleed?

□YES □NO Have you been instructed on the correct method of brushing your teeth and flossing your teeth?

□YES □NO Have you ever been told you have gum disease?

□YES □NO Do you habitually clench your teeth during the day or night?

□YES □NO Any part of your mouth sore to pressures or irritants (cold, hot, pressure, sweets, etc)
If so, where?_____

Signature:_____

Date:_____

# HIPAA Patient Signature Form

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature:_____

Date:_____

**Darlyne M. Loper, D.M.D.**
**1279 W Littleton Blvd**
**Littleton, CO 80120**
**303-794-3969**

Today's Date_____

Patient Name_____

Parent's Name_____
(if patient is a minor)

Address_____

_____

Driver's License Number_____
Expiration Date_____ State of Origin_____

We will gladly file your insurance claim for you. We will be informing you of your estimated copayment for the portion that your insurance will not cover. Your dental insurance carrier may pay less than estimated on the actual bill for services rendered. You will be billed for any remaining charges not covered by your insurance after we receive the insurance payment. We will expect the copayment to be paid at the time of the appointment and any remaining balance after the insurance payment is received to be paid within 30 days

If no insurance exists, our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager.

If your account is not paid within 90 days of the time of service and no financial arrangements have been made, your account will incur a charge of 1.75% interest compounded monthly (21% annum). In addition, in the event your account is referred to a collection agency, you will be responsible for an additional 50% of the balance of the account to cover legal fees, collection agency fees, court costs or any other expense incurred in collecting your account.

Due to the recent increase in last minute cancellations, a $50 fee will be incurred for No Show and Less Than 24-hours Notice of Cancellation.

**Signature**_____ **Date**_____
Patient/Parent or Guardian