204 E. Baseline Rd.
Lafayette, CO 80026
303-665-4000
www.DentistLafayette.com

Name: _____
Last First MI Title

Preferred Name: _____

Address: _____ City _____ State _____ ZIP _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married

How did you hear about our office: ☐ Friend/Family –Who?_____ ☐ Int. Search/Keyword _____ ☐ Other_____

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I certify that I (or my dependent) have insurance coverage and assign directly to Complete Family & Aesthetic Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures, treatment, and photos by the dentist necessary for thorough, comprehensive dental care.

Parent/Guardian Signature: _____

Financial Policy

Dr. Wehking believes in providing the finest possible dental care for you and your family. We want you to feel welcome and as comfortable as possible throughout your treatment. This includes understanding your treatment options as well as our financial policy.

Financial Policy: Payment is expected and due at the time of service. This includes any deductible or patient portion, or payment in full. We accept cash, check and all credit cards. Outside financing is available through Care Credit.

Insurance: Your dental insurance is a contract between you and your dental insurance company. As a courtesy to you we will file your insurance claim, but the responsibility for payment will remain with you regardless of insurance coverage. Please understand that we can provide an insurance **estimate** to you, however we can make no guarantee that insurance will pay exactly as estimated. Insurance coverage is subject to contract restrictions, limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility to understand. We will do our best to help you understand your dental benefits, but ultimately all charges for services in our office are your responsibility. We do not file medical claims or Workmen's Compensation Plans. By signing this, you authorize our office to release any medical or dental information required to process your claims and you authorize that your insurance benefits will be paid directly to our office.

Missed Appointments and Cancellations: Your appointment is reserved exclusively for you. We ask that if you must reschedule your appointment that you provide us with at least **24 hours notice in order to avoid a charge of** $75 for each hour that was reserved for your appointment. This fee is not covered by your dental insurance and is due prior to your next appointment

Divorced Parents: The parent who brings the child in for treatment is the responsible party and the person who is responsible for paying the account in full.

Federal Truth in Lending Disclosure: All amounts reflected are due and payable upon receipt. All amounts not received after 60 days of treatment may accrue a 1.5% finance charge, simple interest 18% APR pursuant to ORS 82.0.10. If your account is past due after 60 days and is billed to you through an outside agent a $25 billing fee will apply. All accounts are due in full within 90 days.

Returned Checks: There will be a $50 service charge for any returned checks.

Attorney and Collections: If your account is turned over to a collections agency or the hands of an attorney for collections, you will pay the doctor's attorney fees and collections costs. By signing this you give permission to give any information deemed necessary to the collection agency or attorney so that they may collect your overdue account on our behalf.

Our goal is to make your visits as pleasant as possible. If you have any questions regarding your treatment plan or financial policies, please do not hesitate to ask us.

I certify that I have read and understand the policies of Complete Family & Aesthetic Dentistry.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Complete Family & Aesthetic Dentistry
DR. DAWN WEHKING

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____ Physician's Phone: _____

Date of last visit: _____ Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins, or implants placed? ☐ Yes ☐ No Please list: _____

Are you taking any medications? ☐ Yes ☐ No

Please list each one: _____

Are you currently, or have ever taken, any bisphosphonates (ie: Fosomax, Zometa, Boniva)? ☐ Yes ☐ No

Are you currently taking blood thinners? ☐ Yes ☐ No

Have you ever had any surgical procedures? ☐ Yes ☐ No _____

Please check all that apply to you:

Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Heart Murmur
☐	☐	Alcohol Abuse	☐	☐	Heart Surgery
☐	☐	Allergies	☐	☐	Hemophilia
☐	☐	Anemia	☐	☐	Hepatitis A
☐	☐	Angina Pectoris	☐	☐	Hepatitis B
☐	☐	Arthritis	☐	☐	Hepatitis C
☐	☐	Artificial Heart Valve	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	Joint Replacement
☐	☐	Blood Transfusion	☐	☐	Kidney Problems
☐	☐	Cancer	☐	☐	Liver Disease
☐	☐	Chemotherapy	☐	☐	Low Blood Pressure
☐	☐	Colitis	☐	☐	Mitral Valve Prolapse
☐	☐	Congenital Heart Defect	☐	☐	Pace Maker
☐	☐	Diabetes	☐	☐	Psychiatric Problems
☐	☐	Difficulty Breathing	☐	☐	Radiation Therapy
☐	☐	Drug Abuse	☐	☐	Rheumatic Fever
☐	☐	Emphysema	☐	☐	Seizures
☐	☐	Epilepsy	☐	☐	Sexually Transmitted Infection
☐	☐	Facial Surgery	☐	☐	Shingles
☐	☐	Fainting Spells	☐	☐	Sickle Cell Disease
☐	☐	Fever Blisters	☐	☐	Sinus Problems
☐	☐	Frequent Headaches	☐	☐	Stroke
☐	☐	Glaucoma	☐	☐	Thyroid Problems
☐	☐	HIV + AIDS	☐	☐	Tuberculosis
☐	☐	Heart Attack	☐	☐	Ulcers

Allergies

Yes	No	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other _____

If female, please answer

Yes	No	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant?
		If so, how many weeks?___
☐	☐	Are you nursing?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Complete Family & Aesthetic Dentistry
DR. DAWN WEHKING

Dental History

How may we help you today? _____

Are you currently in pain? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Are you happy with the appearance of your teeth? ☐Yes ☐No

If no, please explain _____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Have you ever had gum treatment and/or deep cleaning? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Does your jaw joint click? ☐ Yes ☐ No Did your jaw joint use to click, but doesn't anymore? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you get frequent headaches? ☐ Yes ☐ No If yes, how often? _____

Are your teeth sensitive to: ☐ Heat ☐ Biting ☐ Cold ☐ Other _____

Do your gums bleed? ☐ Yes ☐ No

How many times do you: Floss/week? _____ Brush/day? _____

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No If yes, please explain _____

When was your last preventative hygiene appointment? _____ When was your last dental visit? _____

Name of your previous dentist? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Complete Family & Aesthetic Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our team to discuss with you during your visit.

Whitening	Veneers
TMJ/Headache Treatment	Crown and Bridge
Smile Makeover	Nightguards
Replace Missing Teeth	Invisalign or Traditional Braces

HIPAA

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent/Limited Authorization & Release Form

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

Section A: Patient Giving Consent:

Name _____

Address _____

Phone Number _____ Email _____

Please list any other parties who can have access to your health information (this includes step parents, grandparents, and any care takers who can have access to the patient's records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Section B, to the patient-- Please read the following statements:

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations of the uses and disclosures we may make of your protected health information; Including other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice containing the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practice, including any revisions of our Notice, at the time by contacting:

Dawn Wehking DDS
303-665-4000
204 E. Baseline Rd. Lafayette, CO 80026

I have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practies. I understand that by signing this consent form I am giving my consent to use and disclosure of my protected health care information to carry out treatment, payment activities, and health care operations.

Signature _____ Date _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representative's name: _____ Relationship: _____