Contact Information

Full Name: ______________________________ DOB: ______________ Married: ___ Single: ___

Preferred Name: ______________________________ Referred by: ______________________________

Social Security: ______________ Preferred Email: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Home Phone: ___________ Cell Phone: ___________ Work Phone: ___________ *please indicate preferred

Name of Employer: ______________________ Address: ______________________

Emergency Contact

Name: ______________________ Phone: ______________________

Address: ______________________ City: ______________ State: ____ Zip: _____

Communication Preferences

We are committed to protecting the privacy of our patients. We utilize all contact information in a responsible and professional manner. Contact information provided will be used for the following purposes: To open and update patient files, invoice patient accounts, process payments, process claims from insurance companies, send reminders to patients, send informational material about our practice, and when permitted or required by law.

Glenn Family Dentistry may communicate with me regarding clinical information and any/all of the above via the following methods: ____ Texts _____ Voicemail ____Email _____Calls to preferred number

Please list any other person/s we may share clinical and appointment related information with:

Name______________ Relationship___________ Name______________ Relationship___________

Name______________ Relationship___________ Name______________ Relationship___________

*Please note – we will not be able to speak with a spouse or parent of a legal adult child without this information for legal patient privacy.

You can withdraw my consent to electronic communications at any time by calling Glenn Family Dentistry at 303-779-2592 or emailing contact@glennfamilydentistry.com

Insurance Policy Information

Insurance company:__________ Name of Primary Insured: ______________ Date of Birth: __________

Member ID: ___________ Employer: ________________ Insurance company phone: ____________

Patient/Guardian Signature: ______________________________ **Date:** ______________

Thank you for choosing Glenn Family Dentistry as your dental health provider. It is our goal to provide you with the best care possible, to exceed your expectations, and to effectively handle your account. Our office policies apply to ***all*** patients and are necessary in order to provide fair and equal treatment. We are happy to answer any questions you may have regarding these policies at any time.

Insurance and Payment Policies

- **Payment for dental service is expected when treatment is rendered.** You will be informed of your payment or co-payment responsibility at the time treatment is completed so that you may make payment at that visit.
- Our office is willing to accept direct payment from your dental plan, Visa, Mastercard, Discover, American Express, Checks, or cash.
- Dental plans in the marketplace today are too numerous and varied to allow us to know the details of all of them. Your particular dental plan may or may not cover the full extent of the costs you incur for your dental treatment.
- **Please review your dental plan carefully to ensure you understand the exclusions and limitations of your plan. If your dental plan does not cover the full cost of treatment, you will be responsible for any difference.**
- Any returned checks will be charged at $25 Fee in addition to the amount of the check.
- A finance charge of 18% applies to all accounts over 30 days.

Cancellation Policy

- Your appointment time is reserved specifically for you. As a courtesy to the Doctors and other scheduled patients, we ask that you keep your appointments and arrive on time.
- If you need to cancel or change your appointment, we request 72-hour notification. However, **a 48-hour notice is required**.
- **Missed or cancelled appointments with less than 48-hour notice will be assessed a minimum of a *$75.00* cancellation fee**
- We understand that there may be circumstances outside your control in which you are unable to provide the required notice. These will be reviewed on an individual basis.

Consent

I certify that I have read and understand the above information. I understand it is my responsibility to ask questions regarding these policies if my understanding is unclear. By signing, I hereby authorize the Doctors and appropriate staff to perform any and all diagnostic and treatment procedures deemed necessary. If I ever have any change in my health or change in my medication, I will inform the office at my next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of any necessary information in pursuit of these claims.

Print Name:_______________________________________ Date:______________________

Signature: ____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: ______________________________ Date of Birth: ____________

I have received Glenn Family Dentistry's Notice of Privacy Practices written in plain language. The Notice provides uses and disclosures of my protected health information that may be made by Glenn Family Dentistry, my individual rights, and the Glenn Family Dentistry's legal duties with respect to my protected health information.

The Notice includes the following information:

- A statement that Glenn Family Dentistry is required by law to maintain the privacy of protected health information.
- A statement that Glenn Family Dentistry is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that Glenn Family Dentistry is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which Glenn Family Dentistry is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to file a complaint with Glenn Family Dentistry and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that Glenn Family Dentistry is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from Glenn Family Dentistry upon request.

Glenn Family Dentistry reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain Glenn Family Dentistry's current Notice of Privacy Practices on request.

Signature: ____________________________________ Date: ________________

Relationship to Patient *(if signed by a personal representative of patient)*: ____________________

REQUEST OF RECORDS AUTHORIZATION

Please send my most current Bitewings, Panorex, and Full Mouth Radiographs to Glenn Family Dentistry

Patient Name: ____

Patient Signature: ____ Date: _________________

FMX Date: __________
BWX Date: __________
Pano Date: __________
Last Prophy & Exam Date: _________

Glenn Family Dentistry
Megan E. Harbaugh, D.D.S.
3600 South Beeler Street, Suite 120
Denver, CO 80237

Phone: (303) 779-2592
Fax: (303) 779-2522
contact@glennfamilydentistry.com
http://www.glennfamilydentistry.com

Glenn Family Dentistry

glennfamilydentistry.com
3600 S. Beeler Street, Ste 120 • Denver, CO 80237
contact@glennfamilydentistry.com
(303)779-2592

Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

We value your health and your privacy. As always in our practice, your health information is protected and will be kept confidential. All information included in this form is only asked in order that we may treat you safely and with the utmost of care.

Medical History

Do you have or have you ever had any of the following?

- ☐ Allergies
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arteriosclerosis
- ☐ Arthritis/Gout
- ☐ Artific. Heart Valve
- ☐ Artificial Joints
- ☐ Bleeding disorder/Bruise Easily/Excessive Bleeding
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Blood disease/Hemophilia
- ☐ Cold Sores/Fever Blisters/Oral Herpes
- ☐ Cancer treatment
- ☐ Chronic Pain
- ☐ Cochlear implants
- ☐ Coronary Stint Placed
- ☐ Diabetes I or II
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting spells
- ☐ Frequent Cough
- ☐ GI disorders
- ☐ Glaucoma
- ☐ Growths
- ☐ HIV or AIDS
- ☐ Hay Fever
- ☐ Heart Defect/ Congenital Heart Disorder
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Irregular Heart Beat
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low blood pressure
- ☐ Mental Disorders/Psychiatric Care
- ☐ Malnutrition/Eating Disorder
- ☐ Methemoglobinemia
- ☐ Mitro Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Neurologic Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pre-Med Needed
- ☐ Pregnancy
- ☐ Prev. endocarditis
- ☐ Pulmonary Shunt
- ☐ Respiratory Problems/Lung Disease
- ☐ Radiation Treatment
- ☐ Rapid weight loss
- ☐ Recurrent Infections
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep disorder
- ☐ Stroke
- ☐ Swelling Limbs
- ☐ Systemic lupus
- ☐ Tattoos/Body Piercing
- ☐ Thyroid/Parathyroid problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Unexplained Fever
- ☐ Venereal disease/ STD

If you checked any boxes above, please provide us with dates and details so we may ensure your health and safety:

____

____

____

Do you have any disease, condition, or problem not listed ? If yes, please describe:

____

____

Name of Practice/Primary Care Physician and phone number:

____

____

Have you ever had an allergic reaction to

- [ ] aspirin
- [ ] ibuprofen
- [ ] acetaminophen
- [ ] NSIADS
- [ ] codeine
- [ ] penicillin/amoxicillin
- [ ] sulfa
- [ ] tetracycline
- [ ] erythromycin
- [ ] clindamycin
- [ ] doxycycline
- [ ] gluten
- [ ] tree nuts
- [ ] peanuts
- [ ] fish
- [ ] shell fish
- [ ] iodine
- [ ] milk/dairy
- [ ] soy
- [ ] local anesthetic
- [ ] fluoride
- [ ] latex
- [ ] acrylic
- [ ] metals (including nickel, gold, silver)
- [ ] other

If you checked yes to other allergies, please list in the space provided:

____

____

Have you changed your eating habits or are you on a special diet?

____

____

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? ◯ Yes ◯ No

If yes, please name the physician or dentist making the recommendation and which type of medication has been recommended.

____

____

Have you had an orthopedic total joint (hip, knee, etc) replacement? ◯ Yes ◯ No

If yes, please provide the date of surgery, surgeon's name and note if any complications

____

____

Have you been hospitalized or had any surgeries other than above? (please provide description, surgeon if known, date, and if any complications)

____

____

Do you have any surgeries scheduled? ◯ Yes ◯ No

If yes, please provide description, surgeon's name, and date of upcoming surgery.

____

____

Have you had any injuries that involved your head or neck?

____

____

Please list any medications your are taking including prescription, herbals, oils, or vitamins: (include dosage, how often, times of day taken and what medication is treating)

____

____

____

____

Are you taking, or scheduled to begin taking, Alendronate (Fosamax) or Residronate (Actonel) for Osteoporosis or Paget's disease?

○ Yes ○ No

If yes, in IV form or oral form?

○ IV ○ Oral

Since 2001, have you been treated or are you presently scheduled to begin treatment with intravenous (IV) bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications?

○ Yes ○ No

If yes, please provide dates of treatment

____

____

Females only: Are you currently pregnant? ○ Yes ○ No

Females only: Are you currently nursing? ○ Yes ○ No

Dental History

Name of previous dentist? ____________________

Have your past dental experiences been positive? ○ Yes ○ No

If no, please describe.

____

____

Do you have dental exams on a routine basis? ○ Yes ○ No

Please give the date of your last dental exam (to the best of your knowlege). __________

Do you know what year your last full mouth set of xrays were taken? __________

Do you have a specific dental problem today?

____

____

Would you like to change anything about your smile?

____

____

Do you or anyone in your family struggle with cavities? ○ Yes ○ No

Do you or anyone in your family have periodontal disease? ◯ Yes ◯ No

Have you had Periodontal treatment/surgery? ◯ Yes ◯ No

If yes, please provide type of treatment, date of treatment and name of Periodontist

____

____

How many times per day do you brush your teeth? ____________________

Does food catch between your teeth? ◯ Yes ◯ No

If yes, where? ____________________

How often do you clean in-between your teeth?

◯ I don't floss/ use picks or other devices ◯ A few times a year ◯ Once a month
◯ 1-2 times a week ◯ Once per day ◯ Twice per day

What tools do you use to clean your teeth? (check all that apply)

☐ Manual toothbrush ☐ Electric toothbrush ☐ String floss: Waxed, Glide, Other ☐ Floss picks
☐ Interproximal brushes ☐ Interproximal picks ☐ Waterpik ☐ Air flosser
☐ Other

Notes/Comments:

____

____

Do your gums ever bleed? ◯ Yes ◯ No

If your gums bleed, when and how often?

____

____

Have you every had Orthodontic treatment? ◯ Yes ◯ No

If yes, please provide type of treatment, date of treatment and name of Orthodontist

____

____

Have you had wisdom teeth extracted? ◯ Yes ◯ No

If yes, please provide date of extractions and name of Oral Surgeon

____

____

Do you wear or has it been recommended to wear a removable appliance? (check all that apply)

☐ Orhtodontic retainer ☐ Night guard ☐ Snore appliance ☐ Partial denture ☐ Full denture

Do you clench or grind your teeth during the day? ◯ Yes ◯ No

Have you been made aware of clenching or grinding your teeth during sleep? ◯ Yes ◯ No

Do you have chronic headaches, neck, or shoulder pain? ◯ Yes ◯ No

Are your teeth or jaws tired when you awaken? ◯ Yes ◯ No

Have you ever had pain in your jaw joints, sides of your face, or ears? ◯ Yes ◯ No

Have your jaws ever clicked or popped when you open your mouth? ◯ Yes ◯ No

Has your jaw ever locked open or closed? ◯ Yes ◯ No

Have you ever experienced difficulty moving your jaw or opening your mouth wide? ◯ Yes ◯ No

Do you chew on only one side of your mouth? ◯ Yes ◯ No

How often do you wake in the morning with headaches or jaw pain/discomfort?
◯ Never ◯ Rarely ◯ Every day ◯ Weekly ◯ Monthly

Has anyone ever told you that you snore? ◯ Yes ◯ No

Have you ever had a sleep study or wanted to? Why?

____

____

If you have been diagnosed with Sleep Apnea, do you wear:
◯ CPAP ◯ BiPAP ◯ Oral Appliance ◯ Other

Have you ever smoked cigarettes or marijuana? ◯ Yes ◯ No

If yes, do you still currently smoke or vape? ◯ Yes ◯ No

If yes, how often?
☐ 1x or less/ week ☐ 2-7x/ week ☐ 1-4x/day ☐ more than 5x/day

Have you ever had an alcoholic beverage? ◯ Yes ◯ No

How many glasses of beer or wine do you consume per week?

◯ 1 or less ◯ less than 5 ◯ less than 10 ◯ more than 10

How many shots of spirits per week?
◯ Less than 1 ◯ Less than 5 ◯ Less than 10 ◯ More than 10

Do you ever combine alcohol with smoking? ◯ Yes ◯ No

Have you ever had any sores in your mouth? ◯ Yes ◯ No

If yes, please describe.

____

____

Are you being treated or have been treated for drug addiction/alcoholism? ◯ Yes ◯ No

If yes, please describe.

____

____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

◯ Yes ◯ No

Signature ______________________________ **Date** __________

To be completed by your practitioner

Reviewed by Dr.

◯ Megan Harbaugh, D.D.S. ◯ Amber Gotch, RDH ◯ Amy Fink, RDH ◯ Visiting Practitioner

Today's BP __________________

Today's Pulse __________________

Any other significant findings?

____

____

Signature ______________________________ **Date** __________

Response Date: __________