Jennifer Unger Waters, D.D.S., P.C. – 1607 Washington Avenue – Golden, CO 80401 – (303)279-6621

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.
We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

NAME_____

ADDRESS_____

CITY_____STATE_____ ZIP CODE_____

MAILING
ADDRESS_____

CITY_____ STATE_____ ZIP CODE _____

HOME PHONE_____WORK PHONE_____ CELL PHONE_____

SEX Male___ Female___ EMAIL ADDRESS_____

BIRTHDATE_____ AGE_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

NOTIFY IN CASE OF
EMERGENCY_____

PHONE NUMBER_____ RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION

POLICY HOLDER'S NAME_____ SS #_____

RELATIONSHIP TO
PATIENT_____BIRTHDATE_____

INSURANCE
COMPANY_____

INSURANCE
ADDRESS_____

INSURANCE PHONE_____GROUP NUMBER_____

DENTAL HISTORY

FORMER DENTIST_____ PHONE NUMBER_____

ADDRESS_____

DATE OF LAST DENTAL CARE_____ DATE OF LAST X-RAYS_____

WHAT WOULD YOU LIKE TO HAVE DONE TODAY?

_____

ARE YOU IN DENTAL DISCOMFORT TODAY? YES NO
IF YES, PLEASE EXPLAIN_____

_____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____
DO YOU USE A MANUAL OR ELECTRIC TOOTHBRUSH?_____
HOW OFTEN DO YOU FLOSS YOUR TEETH? _____
HOW OFTEN DO YOU USE MOUTH RINSE? _____

Check if you have had any problems or have questions regarding the following:

- ❑ Bad Breath
- ❑ Snoring
- ❑ Bleaching
- ❑ Cosmetic Dentistry
- ❑ Tooth Replacement
- ❑ Bleeding Gums
- ❑ Loose teeth
- ❑ Popping or Clicking in the Jaw
- ❑ Pain or Ringing in the Ear
- ❑ Difficulty opening your Mouth Wide
- ❑ Clenching or Grinding your Teeth
- ❑ Fatigue in Your Face or Jaw When You Awake
- ❑ A Habit of Breathing Through Your Mouth
- ❑ Periodontal Treatment with Deep Cleaning
- ❑ Sensitivity to Hot or Cold
- ❑ Sensitivity to Sweets
- ❑ Sensitivity to Biting
- ❑ Sleep Breathing Disorders
- ❑ Sores or Growths in the Mouth

Have you ever had:

- ❑ Adverse reaction to dental anesthetic?_____ If yes please explain._____
- ❑ Nitrous oxide
- ❑ Allergy to Latex
- ❑ Slow healing sores on the lips or in the mouth
- ❑ Gum surgery
- ❑ Complications following dental treatment
- ❑ TMJ or TMD problems

HEALTH HISTORY

Do you have a family physician?_____
Name_____ Phone _____
Do you use Tobacco Products?_____
Type _____(cigarettes, pipe, cigar, snuff, etc.)
Quantity _____(packs/day, pipefuls, cans etc.)
How long_____(months, years)

Have you experienced any allergic reactions to any medications?_____
Medication Names _____
What Happens?_____

Have you ever taken any bisphosphonate drug such as Fosamax, Actonel, Boniva, Zometa, Didronel, Reclast, Atelvia, Aclasta, Binosto, Skelid, Aredia or other medication for bone density and osteoporosis prevention? YES_____ NO_____

Have you taken any medications in the last six months?_____
Reason_____ Please list._____

Please list medications you are taking now.

_____
_____

Do you use recreational drugs? If yes, then how often?_____

Please check if you have had any of the following:

- ❑ AIDS/HIV Positive
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Atopic (allergic) Reactions

- ❑ Back Problems
- ❑ Blood disease
- ❑ Bleeding or Bruising Easily
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Cold Sores
- ❑ Chemotherapy
- ❑ Cortisone Treatments
- ❑ Persistent Coughing
- ❑ Congenital Heart Disease
- ❑ Car Accident
- ❑ Diabetes
- ❑ Difficulty Hearing
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fibromyalgia
- ❑ Food Allergies
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Heart Surgery
- ❑ Hemophilia/ Abnormal Bleeding
- ❑ Herpes
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Hospitalization
- ❑ Hereditary Diseases or Deformities
- ❑ Human Papilloma Virus (HPV)
- ❑ Jaw Pain
- ❑ Jaundice/ Liver Disease
- ❑ Kidney Disease
- ❑ Material Allergies
- ❑ Mitral Valve Prolapse
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Steroid Therapy
- ❑ Thyroid Disease or Malfunction
- ❑ Tonsillitis
- ❑ Tumor

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that the information will be used by the dentist to determine the appropriate and healthful dental treatment. If there is any change in my health status I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether of not paid by insurance. I also understand that Dr. Waters office will do their best to track benefits but do not always have the ability to be accurate depending on the circumstance. I will be ultimately responsible for tracking the benefits and maximum for my own dental insurance.

Patient Signature _____ Date _____

Reviewed by _____ Date _____

Notice of Privacy Practices Acknowledgement

Jennifer Unger Waters, DDS
1607 Washington Avenue
Golden, CO 80401

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

1. Date	*2. Initials*	Reason

Patient Information for Laser Bacterial Reduction

We are constantly learning and striving to advance the standard of patient care in our office. As such we have recently added a new procedure to your routine cleaning care to help fight periodontal disease.
Periodontal disease effects approximately 80 % of adults and is a growing epidemic in our society. Understanding of this disease has increased greatly over the last few years. We know that periodontal disease is a bacterial infection of the gum pockets around the teeth. As such, we **now** not only treat periodontal disease with the removal of mechanical irritants and diseased tissue (your normal cleaning), but are also addressing the underlying infection that causes it. With that thought in mind, we recommend that all of our patients have their teeth decontaminated prior to cleaning appointments for three major reasons.

1. **To reduce or eliminate bacteremias.** During the normal cleaning process most patients will have some areas that may bleed, this allows bacteria that are present in all of our mouths to flood into the blood stream and sometimes settle into weakened areas of our body such as a damaged heart valve or an artificial joint. We premedicate those patients that we know have a heart condition or artificial joints with antibiotics so that these bacteria can't cause harm to these areas. Latest research shows that these pathogens have now been linked with a number of diseases such as cardiovascular disease, rheumatoid arthritis, low birth weight babies, diabetes etc. Needless to say, anything that we can do to reduce or eliminate these bacteremias is a positive for our patients.
2. **To prevent cross contamination** of infections in one area of the mouth to other areas. Decontamination minimizes the chance that we may inadvertently pick up bacterial infection in one area of your mouth and move it to others.
3. **To kill periodontal disease bacteria** and stop their infections before they cause physical destruction or loss of attachment around your teeth.

The laser decontamination process is painless and usually takes about 5 – 10 minutes. We **highly** recommend that you take advantage of this service as a part of your routine cleaning.
Laser decontamination is $27 and is **NOT** covered by insurance. Unfortunately, insurance coverage is almost always behind the leading edge in high tech health care.
Please ask your hygienist if you have any questions regarding this treatment. Please sign your consent to accept or decline treatment below.

___I want laser decontamination as part of my routine cleaning.
___I decline laser decontamination as part of my routine cleaning.

Signature **Date**

Missed Appointment Policy

- We require a 48 business hour notice when canceling or rescheduling your appointment.
- In the event you miss 1 appointment in our office without a 48 business hour notice, you will not be charged for that appointment.
- In the event that you miss a 2nd appointment in our office without a 48 business hour notice, there will be a $75.00 dollar charge.
- If there is a third missed appointment, you will be dismissed from our practice.

Office Hours

Monday, Tuesday, Thursday	7:30am – 4:30pm
Wednesday	CLOSED
Friday	7:30am – 12:30pm

I would like to be notified of my appointments via:

(Please Choose 1)

_____E-mail @ this address _____
_____ Text Message @ this _____
_____ Phone Calls as usual _____

I _____
authorize Clear Creek Dental Clinic to contact me via e-mail/text messaging for any and all upcoming appointments.

_____ _____
Patient Signature Date