ROCKY MOUNTAIN
PERIODONTAL
SPECIALISTS, L.L.C.
PERIODONTICS • DENTAL IMPLANTS

Geoffrey B. Haradon, D.D.S. - Board Certified
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# 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'll be glad to help you. We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Date _____ Home Phone _____ Business Phone _____ Birthdate _____

Name _____ Social Security # _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Sex ❑ Male ❑ Female Height _____ Weight _____ Age _____ ❑ Single ❑ Married Spouse's Name _____

Employer _____ Occupation _____

General Dentist's Name _____ Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

## PRIMARY DENTAL INSURANCE

Subscriber Name: _____ Relation to patient _____ Birthdate _____

Address (If different from patient's) _____ Social Sec # _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Bus. Phone _____

Insurance Company _____ Group # _____ Subscriber No. _____

Mailing Address _____

## ADDITIONAL DENTAL INSURANCE

Subscriber Name: _____ Relation to patient _____ Birthdate _____

Address (If different from patient's) _____ Social Sec # _____

Person Responsible Employed By _____ Bus. Phone _____

Insurance Company _____ Group # _____ Subscriber No. _____

Mailing Address _____

### OFFICE HOURS

| | |
|---|---|
| Monday | Closed |
| Tuesday–Friday | 8:00 a.m. - 5:00 p.m. |

### EMERGENCY CARE

We provide 24-hour emergency care for our patients. Calls received early in the day will usually permit us to arrange for emergency treatment that day. Should problems occur after working hours, our office phone number will have information regarding emergency care.

### FINANCIAL POLICIES

- Full payment will be collected for all services rendered unless other financial arrangements have been made. We accept cash, check, Visa or MasterCard.
- A service fee of $30.00 will be applied for all returned checks.
- Individual financial arrangements can be made for patients requiring extensive treatment.
- Past due account balances (over ninety days) will accrue a finance charge of 8% annually.
- Delinquent accounts will be released to a private Collection Agency. A $50.00 processing fee will be added to your account balance.

### PATIENTS WITH DENTAL INSURANCE

- As a courtesy to our patients we will process insurance claims for you. If we submit insurance claims on your behalf, payment of benefits will be made directly to this office in most cases. ***The insurance section on this form must be completed in its entirety and signed*** before we can submit your claims.
- ***We stress that insurance is an agreement between the individual and their respective insurance company. The ultimate responsibility of payment for professional services remains that of the patient.***
- We are unable to file ***MEDICAL*** insurance. If your medical plan covers the charges here, we will be glad to give you the appropriate information so that you may file the claim yourself.

### CANCELLATION POLICY

Out of respect to all of our patients and health care providers, our office has established a ***24-hour cancellation policy for all hygiene/evaluation appointments and a 48-hour cancellation policy for surgeries.*** Other than acute illness, inclement weather or an emergency there will be a ***cancellation fee*** of ***$50.00 for hygiene/evaluations and $200.00 for surgeries.*** Your time is valuable, as is ours; therefore, we strive to keep our appointments on schedule and expect promptness and dependability on your part. We appreciate your cooperation.

**I verify that I have read and do agree to abide by the office policies set forth above.**

Patient Signature Required _____ Date: _____

## DENTAL HISTORY

Are you now in discomfort requiring immediate attention? ☐ Yes, explain ☐ No _____

Are you under the care of a dentist? ☐ Yes, explain ☐ No _____

How long have you been a patient of your present dentist _____ How would you rate your past dental care? _____

Date of last professional cleaning _____ How often do you receive dental cleanings? _____

How long have you known about your gum condition? _____ How often do you brush your teeth? _____ Floss? _____

| | | | |
|---|---|---|---|
| Have you ever been treated for periodontal disease | ☐ Yes ☐ No | Do your gums bleed? | ☐ Yes ☐ No |
| Do you have difficulty chewing your food? | ☐ Yes ☐ No | Are your teeth sensitive to temperature or sweets? | ☐ Yes ☐ No |
| Do you clench or grind your teeth? | ☐ Yes ☐ No | Are spaces developing between your teeth? | ☐ Yes ☐ No |
| Do you have or wear a bite guard / splint? | ☐ Yes ☐ No | Have you noticed your bite changing? | ☐ Yes ☐ No |
| Are you aware of breath odor? | ☐ Yes ☐ No | Do you have frequent cold/canker sores? | ☐ Yes ☐ No |
| Do you frequently breathe through your mouth? | ☐ Yes ☐ No | Do you have pain in your jaw joints? | ☐ Yes ☐ No |
| Have you ever had orthodontic treatment? | ☐ Yes ☐ No | Have you ever had injuries to your teeth or jaws? | ☐ Yes ☐ No |
| Have you ever had problems with extractions? | ☐ Yes ☐ No | Does food wedge between your teeth? | ☐ Yes ☐ No |
| Have you ever had any "gum boils" or gum swelling? | ☐ Yes ☐ No | Has any member of your family lost all their teeth? | ☐ Yes ☐ No |
| Do you have apprehension about dental treatment? | ☐ Yes ☐ No | Has any member of your family had periodontal disease? | ☐ Yes ☐ No |

How do you currently clean your teeth? Describe _____

List any dental aides or rinses that you use. Describe _____

## MEDICAL HISTORY

Physician's Name _____ Date of last Visit _____

Describe any serious illness or operations, _____

Is premedication necessary? ❑ Yes ❑ No

Do you take aspirin on a routine bases? ❑ Yes ❑ No

Do you take Fosomax or related drug? ❑ Yes ❑ No

Do you smoke / use smokeless tobacco? ❑ Yes ❑ No How long? _____ Amount _____

**Check ( ✓ ) if you have or have had any of the following:**

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Asthma ❑ Inhaler
- ❑ Hepatitis, Jaundice or Liver Disease
- ❑ Heart Murmur
- ❑ Mitral Valve Prolapse
- ❑ Heart Pacemaker
- ❑ Heart Attack
- ❑ Artificial Joints
- ❑ Anticoagulant
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Cancer / Chemotherapy / Radiation therapy
- ❑ Diabetes
  - Any family history? ❑
  - Do you urinate frequently? ❑
  - Are you often thirsty? ❑
- ❑ Emphysema or chronic bronchitis
- ❑ Stomach or intestinal ulcers
- ❑ Frequent headaches
- ❑ Often unhappy or depressed
- ❑ Anemia or blood disorder
- ❑ Been refused as a blood donor
- ❑ Organ transplant
- ❑ Blood transfusion
- ❑ Under psychiatric care
- ❑ Bruise easily
- ❑ Benign growth
- ❑ Cortisone medication
- ❑ Glaucoma
- ❑ Chest Pains
- ❑ Hives or skin rash
- ❑ Arteriosclerosis
- ❑ Abnormal bleeding
- ❑ Venereal disease
- ❑ Multiple sclerosis
- ❑ Epilepsy or seizures
- ❑ Exhausted or fatigued
- ❑ A nervous person
- ❑ Wear contact lenses
- ❑ Eating Disorders
- ❑ Kidney Disease or Infection
- ❑ Hay Fever
- ❑ Thyroid or parathyroid disease
- ❑ Convulsions or fainting spells
- ❑ Alcohol / Drug use
  - How often? _____
- ❑ Ankle swelling
- ❑ AIDS
- ❑ AIDS antibody (HIV positive)
- ❑ Psychiatric therapy
- ❑ Rapid weight change
- ❑ Under unusual stress or tension
- ❑ Other _____

List any medications you are allergic to: _____

(Women) Are you pregnant? ❑ Yes ❑ No

Nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ Yes ❑ No

**MEDICATIONS (list medications or patches you are currently taking)**

| | | | | | |
|---|---|---|---|---|---|
| _____ | Reason for taking | _____ | Dosage | _____ |
| _____ | Reason for taking | _____ | Dosage | _____ |
| _____ | Reason for taking | _____ | Dosage | _____ |
| _____ | Reason for taking | _____ | Dosage | _____ |
| _____ | Reason for taking | _____ | Dosage | _____ |
| _____ | Reason for taking | _____ | Dosage | _____ |

**To the best of my knowledge all of the preceding answers are true and correct. If I have any changes in my health or if my medications change, I will inform the doctors or their staff at the next appointment without fail.**

PATIENT SIGNATURE: _____ DATE: _____

Rocky Mountain Periodontal Specialists

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____

(date)

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

**ROCKY MOUNTAIN PERIODONTAL SPECIALISTS SERVICES PROVIDER-PATIENT CONTACT AND DENTAL RECORDS RELEASE FORM CONSENT FORM**

I, _____, DOB ____/____/_____ consent and agree that Dr. Geoff Haradon or Dr. Karl Lackler and staff may contact me and leave voice messages as outlined below. **These messages can include appointment information, billing information, information that identifies the practice** as a Periodontal Surgical Practice, and any pertinent clinical information. I understand if I choose the option for callback information only, a message will be left solely with a first name and callback telephone number. I am aware that restrictions placed on where messages can be left may affect clinician and staff ability to contact me with important information.

**I wish to be contacted in the following manner (check all that apply):**

| | |
|---|---|
| **Email Address:**<br>_____<br>**I consent to a message with detail information as outlined above**<br>☐ Yes ☐ No<br>**Leave message with first name and callback number only**<br>☐ Yes ☐ No<br>**Do not leave an email message**<br>☐ Yes ☐ No | **Home telephone number and/or answering machine number**<br>_____<br>**I consent to a message with detail information as outlined above**<br>☐ Yes ☐ No<br>**Leave message with first name and callback number only**<br>☐ Yes ☐ No<br>**Do not leave a message on my home phone number**<br>☐ Yes ☐ No |
| **Work telephone number and/or answering machine number**<br>_____<br>**I consent to message with detailed information as outlined above**<br>☐ Yes ☐ No<br>**Leave message with first name and callback number only**<br>☐ Yes ☐ No<br>**Do not leave a message on my work phone number**<br>☐ Yes ☐ No | **Mobile telephone number and/or answering machine number**<br>_____<br>**I consent to message with detailed information as outlined above**<br>☐ Yes ☐ No<br>**Leave message with first name and callback number only**<br>☐ Yes ☐ No<br>**Do not leave a message on my mobile phone number**<br>☐ Yes ☐ No |
| **Correspondence involving all of the above listed information can be mailed to your home address:** ☐ Yes ☐ No | |

**I request and consent that Dr. Geoff Haradon or Dr. Karl Lackler and staff may contact, leave messages, discuss and give copies of my medical information to the following persons indicated below.**

Name: _____ Relationship: _____ Phone: _____

_____ Discuss medical information _____ Release of Medical Records:

_____ Leave detailed messages _____ Leave callback information only

Name: _____ Relationship: _____ Phone: _____

_____ Discuss medical information _____ Release of Medical Records:

_____ Leave detailed messages _____ Leave callback information only

I understand that I may revoke this consent in writing at any time, except to the extent that action already has been taken relying on this consent.

Patient Signature: _____ Date: _____

**Please provide us with the names and addresses of your General Dentist or Orthodontists; you want our Doctors or Staff to correspond with in regards to your care.**

| *Physician Name* | *Address* |
|---|---|
| | |
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| | |