Patrick T. Prendergast, D.D.S. 6979 South Holly Circle Suite 185 Centennial, CO 80112 303.771.0225

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____ Social Security #: _____
Birth Date: _____ Phone (Home): _____
(Work): _____ Ext: _____ (Cell): _____
E-Mail Address: _____ **Whom may we thank for this referral** _____

Preferred contact method: Home Phone, Cell Phone, Work Phone, E-Mail

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ A.I.D.S./H.I.V Positive
- ☐ Alcohol Abuse
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Anxious
- ☐ Arthritis
- ☐ Artificial Joints (Hip, Knee, Etc.) _____
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bone Grafts
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Cough
- ☐ Circulatory Problems
- ☐ Cold Sores/Fever Blisters
- ☐ Colitis
  - ☐ C-Diff
- ☐ Contact Lenses
- ☐ Cortisone Medicine
- ☐ Cosmetic Surgery
- ☐ Diabetes
  Diet - Restricted
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Dry Mouth
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Goiter
- ☐ Growths
- ☐ Hard of Hearing
  Wear Hearing Aids? Y
- ☐ Hay Fever
- ☐ Head Aches - How often _____
- ☐ Head Injuries _____
- ☐ Hemophilia
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis C
- ☐ Herpes
- ☐ Implants - where?
  Dental _____
  Other _____
- ☐ Jaundice
- ☐ Kidney Disease/Trouble
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Neurological Disorders
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Psychiatric/Psychological Care
- ☐ Radiation Therapy
  Head/Neck? _____
  Date: _____
- ☐ Rapid Weight Loss
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Sickle Cell Disease
- ☐ Sinus or Nasal Trouble
- ☐ Skin Rash
- ☐ Staph Infections
  - ☐ MERSA
- ☐ Stomach Problems
- ☐ Stress
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Disease
- ☐ Tobacco Use - Cigarette, Chew, Pipe
  How Long? _____
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

HEART

- ☐ Angina
- ☐ Artificial Heart Valve
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Palpitations

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____ May we contact? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you need antibiotic premedication before dental treatment? ☐ Yes ☐ No
  What pharmacy would you like your Rx called into? Name: _____ Phone # _____

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ARE YOU USING ANY OF THE FOLLOWING:

Patient Name: _____,

Antibiotics? _____

Anticoagulants (Blood Thinners)? _____

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? _____

Digitalis, Inderal, Nitroglycerin or other heart drug? _____

Diet Drugs Taken: Fen-Phen, Redux _____

High Blood Pressure medications? _____

Insulin or Oral Anti-Diabetic drugs?_____

Steroids (Cortisone, etc.)?_____

Tranquilizers?_____

Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers. ☐ Yes ☐ No

(Please Circle) Actonel Aredia Boniva Didronel Fosamax Reclast Skelif Zometa

How long have you been on bisphosphonate therapy?

_____

Any episodes of osteonecrosis? _____

Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

Have you ever been advised not to take a medication?_____

Any disease, drug or transplant operation that has depressed your immune system: _____

_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

- ☐ Aspirin
- ☐ Chemicals - Rash or Sensitivity
- ☐ Codeine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Penicillin
- ☐ Sedatives, Barbiturates
- ☐ Sulfa Drugs/sulfites/Sulfides
- ☐ Tetracycline
- ☐ Food products (gluten) _____
- ☐ Jewelry - Rash or Sensitivity
- ☐ Latex or Rubber Products
- ☐ Local Anesthesia (Novocain, etc.) _____
- ☐ Metal of any kind
- ☐ Other Antibiotics – please list _____ _____
- ☐ Other allergies or reactions? Please, list
- ☐ Other Pain Meds – please list

FOR WOMEN ONLY

Are you Pregnant, or **is there any chance you might be Pregnant?** _____

Are you nursing? _____ Are you taking pre-natal vitamins? _____

Do you use birth control prescriptions? ☐ Yes ☐ No

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Do you have any other conditions, diseases, or problems not listed above? ☐ Yes ☐ No

If yes, please describe _____

_____

I understand that this information will be used by the dentist and staff to help determine appropriate and healthful dental treatment. If there is any changes in my medical status, I will inform the dentist. Since at each visit a plan of treatment will be presented and the work to be done explained to me before treatment is begun I give the dentist my consent to perform any needed dental treatment.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor and the information I have provided here is complete and accurate.

_____ Date:_____

Please Print Name Signature of patient, parent or guardian

_____ Date: _____

Signature of doctor

Spouse or Responsible Party Information

***Patient Name*:** _____

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____,
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

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Dental Information

Patient Name:_____.
What is the reason for your visit today?_____
Date of Last Dental Visit: _____ Last Dental Cleaning: _____
Last Full Mouth X-rays:_____Last Pano:_____
Previous Dentist's Name:_____
Address: _____
Telephone:_____

How often do you have dental examinations:_____
How often do you brush your teeth?_____How often do you floss?_____
What other dental aids do you use? Please circle: Toothpick, Softpiks, Flosspiks, Sonicare, Oral B, Spinbrush, RX strength toothpaste, MI Paste, Mouthwash, other:_____
Do you have any dental problems now? ☐ Yes ☐ No
If so, please describe: _____

Are any of your teeth sensitive to:
Hot or cold? ☐ Yes ☐ No
Sweets? ☐ Yes ☐ No
Biting or Chewing? ☐ Yes ☐ No
Have you noticed any mouth odors? ☐ Yes ☐ No
bad tastes? ☐ Yes ☐ No
Has anyone told you –you have mouth odor? ☐ Yes ☐ No
Do you frequently get cold sores? ☐ Yes ☐ No
Blisters? ☐ Yes ☐ No
any other oral lesions? ☐ Yes ☐ No
Have you had dry mouth? ☐ Yes ☐ No

Have you ever had:
Orthodontic treatment? ☐ Yes ☐ No
Dental Oral Surgery? ☐ Yes ☐ No
Periodontal treatment – deep cleaning? ☐ Yes ☐ No
Periodontal Surgery? ☐ Yes ☐ No
Your teeth ground or the bite adjusted? ☐ Yes ☐ No
Have you ever worn a bite plate, night guard or mouth guard? ☐ Yes ☐ No
Have you ever had: A serious injury to the mouth or head? ☐ Yes ☐ No
If so, please describe, including cause _____

Do your gums bleed or hurt? ☐ Yes ☐ No
Have your parents experienced gum disease? ☐ Yes ☐ No
Have your parents experienced tooth loss? ☐ Yes ☐ No
Have you noticed any loose teeth? ☐ Yes ☐ No
Have you noticed any change in your bite? ☐ Yes ☐ No
Does food tend to become caught in between your teeth? ☐ Yes ☐ No
If yes, where? _____

Have you experienced:
Clicking or popping of the jaw? ☐ Yes ☐ No
Clench or grind your teeth while awake? ☐ Yes ☐ No
asleep? ☐ Yes ☐ No
Pain - Joint, ear, side of face? ☐ Yes ☐ No
Difficulty in opening or closing the mouth? ☐ Yes ☐ No
Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No
Have tired jaws, especially in the morning? ☐ Yes ☐ No
Headaches, neckaches or shoulder aches? ☐ Yes ☐ No
Sore muscles (neck, shoulders)? ☐ Yes ☐ No
Are you satisfied with your teeth's appearance? ☐ Yes ☐ No
Would you like to keep all of your teeth all of your life? ☐ Yes ☐ No

Do you:
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Hold foreign objects with your teeth? ☐ Yes ☐ No
pencils, pipe, pins, nails, fingernails? ☐ Yes ☐ No
Mouth breathe while awake or asleep? ☐ Yes ☐ No
Snore or have any other sleeping disorders? ☐ Yes ☐ No
Smoke/chew tobacco or use other tobacco products? ☐ Yes ☐ No

Would you be interested in tooth
Whitening procedures? ☐ Yes ☐ No
Oral cancer screening? ☐ Yes ☐ No
Bacterial Decontamination? ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No
If so, what is your biggest concern? _____
Have you ever had an upsetting dental experience? ☐ Yes ☐ No
If yes, please describe _____
Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No
If yes, please describe: _____

Children:
Has child complained about dental problems? ☐ Yes ☐ No
If so, explain:_____
Does child brush teeth daily? ☐ Yes ☐ No
Does child use floss every day? ☐ Yes ☐ No
Is fluoride taken in any form? ☐ Yes ☐ No
Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?
_____

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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

For Office Use Only

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)**

_____

_____

_____

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General Consent

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statements on this page:

_____.

_____
Patient Signature Date

_____
Parent's Signature (if minor patient) Date

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In our continuing efforts to provide the most advanced technology and highest standard of care available to our patients, this practice is proud to announce the inclusion of the **ViziLite Plus** annual exam as an integral part of our comprehensive oral screening program and **Laser Bacterial Reduction** at your routine teeth cleaning appointments.

One person dies every hour from oral cancer in the United States – and the mortality has remained unchanged for more than 40 years. Late detection of oral cancer is the primary reason that both the incidence and mortality rates of oral cancer continue to increase. As with most other cancers, **age is the primary risk factor for oral cancer.** Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.** According to the American Cancer Society, more women in the United States will be diagnosed with oral cancer this year than will be diagnosed with cervical cancer.

Clinical studies have determined that using ViziLite Plus after the standard oral cancer examination improves the dental professional's ability to identify and evaluate suspicious areas at their earliest stages. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is an easy and painless examination that gives this practice the best chance to find any oral abnormalities you may have at the earliest possible stage.

This practice prescribes the ViziLite Plus exam for all patients at increased risk, high risk and highest risk for oral cancer (adult patients age 18 and older and tobacco users of any age). With your permission, we will be performing the ViziLite Plus exam annually following the standard oral cancer examination of the oral cavity for a fee of $ 45.00.

Periodontal disease affects 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 now know that Periodontal Disease is a **bacterial infection in the pockets around teeth.** As such, we now not only treat Perio with 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 bloodstream and sometimes settle in weakened areas of our body such as a damaged heart valve or artificial knee or hip, etc. We pre-medicate 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 oral pathogens have now been linked to a number of other 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 your 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 normally takes about 5 – 10 minutes. Laser decontamination is $ 30.00 and is NOT covered by insurance. Unfortunately insurance coverage is almost always behind the leading edge in high tech health care.

Please sign and date that you have received this information _____

«FName» «LName» Date Signed