Margot Sullivan, DDS, PC
2599 Wadsworth Blvd St. 3
Lakewood, CO 80214
303-421-4820

Date_____
Name_____Soc. Sec #_____
Address_____City_____State_____Zip_____
Home/Cell phone #_____Work#_____Best # to reach you_____
Sex: ☐F ☐M Age_____ DOB_____ Marital Status _____

Patient employed by:_____Occupation:_____
Address:_____Phone:_____
Email address:_____
Whom may we thank for referring you?_____
In case of emergency, who should be notified?_____Phone:_____

Dental Insurance:
Do you have dental insurance?_____Can you go to the Dentist of your choice?_____
Name of Insurance Co_____
Who is the insurance under?_____Relationship to patient_____
DOB:_____Soc Sec #_____Occupation_____
Address (if different than above)_____
Employer's address_____
*Please give us a card to make a copy of you have one.
Give us any info you can provide if you do not have a card:
Ins Co._____Group #_____Subscriber#_____
Address & Phone_____
Do you have secondary Dental Insurance through your spouse?_____

Dental History

Please answer the following:

Main complaint if any_____
Last time you saw a Dentist_____Date of last X-rays_____
Former Dentist_____
Y/N –Do you have any loose, broken, or missing teeth?
Y/N –Are you having pain or swelling in your mouth?
Y/N –Do you smoke or chew tobacco?
Y/N –Do you have problems with mouth sores? (cold sores, canker sores)
Y/N –Have you had orthodontics/ braces in the past?
Y/N –Have you had periodontal treatment?
Y/N –Do you have dental implants?
Y/N –Do you wear a night guard/ splint?
Y/N –Have you ever had clicking/ popping/ pain/ limited opening or other TMJ problems?
Y/N –Have you had your wisdom teeth out?
Y/N –Have you had your tonsils removed?

I am interested in: *(please check any that apply)*

___comprehensive & preventative care
___emergency care only
___dental implants
___tooth bleaching
___pretreatment estimates from my Insurance co. to determine exact co-payment
____reducing sensitivity
____oral cancer screening light Velscope ($35)
____nitrous Oxide ($65)
____laser bacterial reduction with my cleaning ($27)

□Heart Problems
__Anemia
__Heart Attack
__High Blood Pressure
__Heart Murmur __premed
__Stents
__Artificial valves
__Surgeries
__Swelling of feet/ ankles
__Pacemaker
__Mitral valve prolapse
__Rheumatic Fever/ Scarlet Fever

□Lung Problems
__COPD
__Emphysema
__Shortness of breath
__Chronic Cough
__Tuberculosis
__Asthma __inhaler?
__Do you use Oxygen?
__Other

□Liver Problems
__Hepatitis
__Cirrhosis

□Kidney Disease

□Cancer
Type:_____
Date(s):_____
Chemo?_____
Radiation?_____

□Blood Diseases
__Hemophilia
__Anemia
__Other

□Artificial Joint Replacement
Which joint(s)_____
When_____
Premed_____

□Diabetes
What type_____
Insulin?_____

Others:
__Stroke
__Epilepsy
__Seizures
__Fainting
__HIV/AIDS
__Skin Rash
__Cortisone Treatment
__Back problems
__Glaucoma
__Ulcer
__Tobacco Habit_____
__Venereal disease
__Thyroid Problems:
__hyper
__hypo
__Drug/ Alcohol addiction
__Other:_____

Allergies:

_____
_____
_____
_____

List all current medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Physician's Name:_____ Phone:_____
Last Visit:_____
Pharmacy Name:_____Phone:_____
Are you under the care of a specialist?_____
Have you had any operations/illnesses?_____
_____
(Women) Are you pregnant?_____Nursing?_____Taking birth control pills?_____
Have you taken medication for osteoporosis?_____Biophosphates?_____
Are you taking any natural/ herbal supplements?_____

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)

_____

_____

_____

Letter of Understanding

Office Insurance policy

Patient_____

Date_____

We are pleased that you have dental insurance to help with your dental needs. We are happy to help you navigate your insurance as it pertains to our office. Please understand that although we accept most insurances, we are not affiliated with the dental insurance companies. So please keep in mind that:

- Your dental benefits are under contract between YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. WE ARE NOT PARTY TO THAT CONTRACT.
- Our fees generally are NOT fully covered by the maximum allowance determined by your carrier
- YOU are responsible for ALL fees incurred for services rendered to you
- Please discuss your proposed dental treatment with us and bring up any insurance concerns before we begin treatment.
- We will submit all claims to your insurance but, you are responsible for your account balance.

ANY ACCOUNT THAT GOES UNPAID AFTER 90 DAYS WILL BE SENT TO A COLLECTION AGENCY, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

I understand and agree to this policy

Patient Signature_____

Date_____