ELEVATE
dental wellness

PATIENT INFORMATION:

·**Full Name:**_____

·**Preferred Name:**_____

·**Date of Birth:**_____

·**Male / Female**

·**Child lives with (circle option):**

Both parents *Mother* *Father* *Other*

·**Is the person filling out this form responsible for payment on this account?**

YES *NO*

·**Please fill out if the patient has dental insurance coverage:**

Insurance Company Name:_____

Insurance Company Address:_____

_____

Insurance Company Phone Number:_____

Group #:_____

INSURED'S Name:_____

INSURED'S relationship to YOU:_____

INSURED'S Date of Birth:_____

INSURED'S SSN and Member #:_____

INSURED'S Employer:_____

INSURED'S Employer's Address:_____

_____

CHILD'S SSN:_____
(required only if filing insurance)

PARENT / LEGAL GUARDIAN INFORMATION:

·**Relationship to Patient:**_____

·**Full Name:**_____

·**Preferred Name:**_____

·**Date of Birth:**_____

·**Male / Female:**_____

·**Email Address:**_____

·**Mailing Address:**_____

_____

·**Phone Number:** cell - _____

work - _____

home - _____

·**SSN or DL / ID Number:**_____

·**Preferred Method of Contact (circle preference):**

Email *Cell* *Home* *Work*

·**May we leave messages of a personal nature on your preferred method of contact?**

Yes *No*

·**How did you hear about us? - or – Whom may we thank for referring you?**_____

_____

·**Occupation:**_____

·**Employer:**_____

·**Employer's Address:**_____

_____

·**If a Student, Name of School:**_____

·**Emergency Contact Information:**_____

_____

PROVIDER INFORMATION:

·Name / Contact Number of Previous Dentist:_____

·Date of last regular check-up and x-rays with dentist:_____

·Pediatrician / Physician Name, Address and Phone Number:_____

·Date of last regular check-up with physician:_____

·Name / Contact Information of any other specialist:_____

GENERAL MEDICAL QUESTIONS (if NO, write "NO"; if YES, please list):

·Is your child under the care of a doctor at the present time?:_____

·Does your child take any medications/supplements?:_____

·Is your child allergic to any medications?:_____

·Is your child allergic to any foods, materials or dyes?:_____

·Has your child had any surgeries?:_____

·Does your child require premedication with antibiotics prior to dental procedures?:_____

ORAL HEALTH and LIFESTYLE HABITS:

·How much water does your child drink per day?:_____

·Does your child drink (circle one): *Bottled water* *Well water* *City water*

·If you have a water filter what type is it (circle one)?: *Carbon* *Reverse Osmosis* *Other*

·Does your child use fluoride toothpaste?: YES NO

·Does s/he swallow the toothpaste?: YES NO

·Brushing Frequency (circle one): *Morning* *Evening* *Both*

·What type of toothbrush does your child use (circle one)?: *Regular* *Power* *Cloth* *Other*

·Dental Flossing (circle one): *Once daily* *Occasionally* *Never* *By parent* *By child*

·Who is responsible for toothbrushing? (circle one): *Parent* *Child* *Both*

·Has your child had orthodontic treatment?: YES NO

·Does your child eat between meals?: YES NO

·Is your child a good eater?: YES NO

·Does s/he eat a balanced diet?: YES NO

·Does s/he drink soda?: YES NO

·Does s/he consume citrus?: YES NO

·My child's sugar consumption is (circle one): *None* *Slight* *Moderate* *High*

·Does s/he snore?: YES NO

·Please list your child's favorite snacks:_____

·Please circle if any of the following exist or have existed: *Thumbsucking* *Grinding teeth* *Pacifier* *Other*

·At what age was bottle / nursing stopped?:_____

MEDICAL HISTORY: Does your child have, ever had, or been diagnosed with any of the following? (circle YES or NO):

·HIV+ / AIDS.....YES NO
·Anemia / Sickle Cell Trait.....YES NO
·Allergy / Hay Fever.....YES NO
·Anxiety / Depression.....YES NO
·Arthritis / Rheumatism.....YES NO
·Artificial Heart Valve.....YES NO
·Artificial Joint or Limb.....YES NO
·Asthma.....YES NO
·Attention Deficit Disorder / ADHD.....YES NO
·Autism Spectrum.....YES NO
·Autoimmune Disease.....YES NO
·B12 deficiency.....YES NO
·Behavior / Learning Disabilities.....YES NO
Circle all that apply:
Problem Learning
Problem Concentrating
Problem Cooperating
Problem Understanding
·Bleeding Disorder.....YES NO
·Birth Defects.....YES NO
·Bone/Joint/Orthopedic Problems.....YES NO
·Brain Surgery.....YES NO
·Cancer.....YES NO
·Chemotherapy / Radiation.....YES NO
·Cerebral Palsy.....YES NO
·Chicken Pox.....YES NO
·Cleft Lip / Palate.....YES NO
·Cold Sores / Fever Blisters.....YES NO
·Convulsions / Seizures.....YES NO
·Diabetes or Familial History.....YES NO
·Digestive Disturbances.....YES NO
·Eating Disorder.....YES NO
·Ear Aches.....YES NO
·Emotional Disturbances.....YES NO
·Epilepsy.....YES NO
·Eye Problems.....YES NO
·Fainting.....YES NO
·Glandular Disturbance.....YES NO
·Head Injury.....YES NO
·Hearing Loss/Aids/Implants.....YES NO
·Heart Murmur.....YES NO
·Heart Problem/Surgery.....YES NO
·Hemophilia.....YES NO
·Hepatitis A, B, or C.....YES NO
·High/Low Blood Pressure.....YES NO
·Hormonal Disturbance.....YES NO
·HPV.....YES NO
·Hydrocephalus.....YES NO
·Immune Suppression.....YES NO
·Kidney Problems.....YES NO
·Leukemia.....YES NO
·Liver Problems.....YES NO
·Malignant Hyperthermia.....YES NO
·Measles.....YES NO
·Mumps.....YES NO
·Mouth Ulcers.....YES NO
·MTHFR.....YES NO
·Nutritional Disturbances.....YES NO
·Organ Transplant.....YES NO
·Pneumonia.....YES NO
·Polio.....YES NO
·Pregnancy.....YES NO
·Reactive Airway Disease.....YES NO
·Respiratory Problems.....YES NO
·Rheumatic Fever.....YES NO
·Scarlet Fever.....YES NO
·Scoliosis.....YES NO
·Sensory Integration Disorder.....YES NO
·Shunts.....YES NO
·Sleep Disorder.....YES NO
·Speech Problems.....YES NO
·Tetanus.....YES NO
·Tonsillectomy.....YES NO
·Tuberculosis.....YES NO
·Tumors.....YES NO
·Whooping Cough.....YES NO

·Does your child have any other condition not mentioned above?:_____

I understand the information I have given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status.

Signature:_____ Date:_____
Doctor's Signature:_____ Date:_____

ELEVATE
dental wellness

711 East Valley Road, Suite 201A
Basalt, CO 81621
Phone (970) 279-5647
frontdesk@elevatewillits.com

Dental Records Release Form

Patient Name to Transfer: _____

Date of Birth: _____

Phone Number: _____

Other Family Members to Transfer:

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Previous Dentist or Practice Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Please forward any of the following information that you have: x-rays, probing depth chart and dental record charting to Elevate Dental Wellness.

I hereby give you permission to release any and all of my dental records to Elevate Dental Wellness.

_____ Date _____
Patient Signature (parent if a minor)

If records are digital, please email to:

frontdesk@elevatewillits.com

Or mail to:

Elevate Dental Wellness
711 East Valley Road, Suite 201A
Basalt, CO 81621

Elevate Dental Wellness

Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Practices, Financial & Rescheduling Policy, and Informed Consent

I have received a copy of the Notice of Privacy Practices (HIPPA), Financial and Rescheduling Policy, and Informed Consent of **Elevate Dental Wellness**. I hereby authorize, as indicated by my signature below, **Elevate Dental Wellness** to use and to disclose my protected health information for any necessary clinical, financial, or insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number: _____
- ☐ You may contact me on my mobile telephone number: _____
- ☐ You may contact me on my work telephone number: _____
- ☐ You may send me an email at: _____
- ☐ Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Relationship: _____ Date __/__/___ added/removed

2. _____ Relationship: _____ Date __/__/___ added/removed

3. _____ Relationship: _____ Date __/__/___ added/removed

****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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify): _____

Staff Person Initials: _____