DATE: _____

BIRTHDATE: _____

NAME: _____

Denver Smiles

Personalized Dentistry

8015 W ALAMEDA AVE STE 115
LAKEWOOD CO 80226
303.623.4444 DENVERSMILES.COM
Hello@DenverSmiles.com

ABOUT YOU

ADDRESS_____UNIT/APT_____ HOME PHONE_____

CITY _____ ZIP _____ CELL PHONE _____

☐MALE ☐FEMALE | ☐MINOR ☐SINGLE ☐MARRIED ☐DIVORCED

EMAIL_____

EMPLOYER _____ BUSINESS PHONE_____

EMPLOYER ADDRESS_____ OCCUPATION _____

EMERGENCY CONTACT_____ PHONE_____

WHOM SHOULD WE THANK FOR REFERRING YOU? _____

DENTAL INSURANCE

POLICY HOLDER FOR ACCOUNT _____

RELATIONSHIP TO PATIENT_____ BIRTH DATE _____ SSN _____

ADDRESS_____ HOME PHONE _____

CITY/STATE _____ ZIP_____

RESPONSIBLE PARTY EMPLOYER_____

INSURANCE COMPANY_____ SUBSCRIBER ID_____

INSURANCE COMPANY ADDRESS_____

INSURANCE COMPANY PHONE NUMBER_____ PAYOR ID_____

DENTAL HISTORY

FORMER DENTIST_____ DATE OF LAST XRAYS_____

CITY/STATE_____ HOW OFTEN YOU FLOSS_____

DATE OF LAST DENTAL VISIT_____ HOW OFTEN YOU BRUSH_____

PLEASE CHECK ALL THAT APPLY:

☐BAD BREATH	☐JAW/HEAD/NECK INJURIES	☐NAIL BITING	☐SENSITIVITY TO HEAT
☐BLEEDING GUMS	☐JAW CLICKING OR PAIN	☐ORTHODONTICS	☐SENSITIVITY TO SWEETS
☐BLISTERS ON LIPS OR MOUTH	☐LIP OR CHEEK BITING	☐PAIN AROUND EAR	☐SENSITIVITY WHEN BITING
☐FREQUENT HEADACHES	☐LOOSE TEETH/BROKEN FILLINGS	☐PERIODONTAL TREATMENT	☐TOOTH PAIN
☐GRINDING TEETH	☐DENTAL ANXIETY OR FEAR	☐SENSITIVITY TO COLD	☐DRY MOUTH

INTERESTED IN ADDITIONAL PREVENTIVE SERVICES? (FLUORIDE, SEALANTS, REDUCING SENSITIVITY, ETC.) ☐YES ☐NO

ADDITIONAL IMPORTANT DENTAL HISTORY _____

_____

MEDICAL HISTORY

PHYSICAN'S NAME_____ DATE LAST VISITED_____

1. CURRENTLY UNDER MEDICAL TREATMENT? ☐YES ☐NO 2. ANY SERIOUS ILLNESSES/OPERATIONS? ☐YES ☐NO

IF YES, PLEASE DESCRIBE ILLNESS/OPERATION_____

_____

3. CURRENTLY TAKING MEDICATIONS? ☐YES ☐NO IF YES, PLEASE LIST MEDICATIONS_____

_____

_____

4. SMOKE/VAPE? ☐YES ☐NO 5. CONSUME ALCOHOL? ☐YES ☐NO 6. RECREATIONAL DRUGS? ☐YES ☐NO

7. WEAR CONTACT LENSES? ☐YES ☐NO 8. ALLERGIC REATIONS TO THE FOLLOWING? (CHECK ALL THAT APPLY)

☐LOCAL ANESTHETICS ☐PENICILLIN / ANTIBIOTICS ☐SULFA DRUGS ☐BARBITURATES/SLEEPING PILLS)

☐SEDATIVES ☐IODINE ☐ASPIRIN ☐OTHER (LIST BELOW)

_____

9. (**WOMEN ONLY**) PREGNANT? ☐YES ☐NO NURSING? ☐YES ☐NO ORAL CONTRACEPTIVES? ☐YES ☐NO

10. DIET/NUTRITION: VITAMINS? ☐YES ☐NO DRINK SODA? ☐YES ☐NO # OF MEALS/SNACKS PER DAY? _____

11. MEDICAL CONDITIONS (CHECK ALL THAT APPLY)

☐AIDS / HIV	☐HEART PROBLEMS	☐DEMENTIA	☐SCARLET FEVER
☐ANEMIA	☐CORTISONE TREATMENTS	☐JAW PAIN	☐SHORTNESS OF BREATH
☐DIABETES LAST A1C _____	☐COUGH (PERSISTANT OR BLOODY)	☐ DATE OF LAST HOSPITALIZATION _____	☐SINUS PROBLEMS ☐SLEEP APNEA
☐ARTIFICIAL HEART VALVE	☐ARTHRITIS, RHEUMATISM	☐LATEX SENSITIVITY	☐SKIN RASH
☐ARTIFICIAL JOINTS	☐EMPHYSEMA	☐KIDNEY DISEASE	☐STROKE
☐ASTHMA	☐SEIZURES	☐LIVER DISEASE	☐SWELLING OF FEET / ANKLES
☐BACK PROBLEMS	☐FAINTING/DIZZINESS	☐	☐SWOLLEN NECK GLANDS
☐ABNORMAL BLEEDING	☐GLAUCOMA	☐MITRAL VALVE PROLAPSE	☐THYROID PROBLEMS
☐BLOOD DISEASE/ISSUE	☐HEADACHES	☐NERVOUS PROBLEMS	☐TONSILITIS
☐CANCER	☐HEART MURMUR	☐PACEMAKER	☐TUBERCULOSIS
☐CHEMICAL DEPENDENCY	☐HEART PROBLEMS	☐PSYCHIATRIC CARE	☐TUMOR/GROWTH ON HEAD OR NECK
☐CHEMOTHERAPY	☐HEPATITIS TYPE ___	☐RADIATION TREATMENT	☐ULCER
☐ HISTORY OF BISPHOSPHONATE USE	☐HERPES	☐RESPIRATORY DISEASE	☐VENEREAL DISEASE/ STD'S
☐CIRCULATORY PROBLEMS	☐HIGH BLOOD PRESSURE / LOW BLOOD PRESSURE	☐RHEUMATIC FEVER	

OTHER IMPORTANT MEDICAL CONDITIONS: _____

_____

FINANCIAL/ CANCELATION POLICY AND AGREEMENT

At Denver Smiles, we are committed to providing exceptional dental care with both a professional and personal touch We believe that financial concerns should never be a barrier to receiving quality treatment, and we want to ensure that you fully understand our financial policies and available options.

DENTAL INSURANCE: If you have dental insurance, our office will complete and submit your insurance claims on your behalf. In order to do so, we require that you provide all necessary and accurate insurance information. Failure to provide complete information may delay the processing of claims and may result in a request for full payment at the time of service. We will make every effort to help you understand your dental benefits. However, **insurance estimates are not a guarantee of payment**. Your estimated co-payment is due at the time services are rendered. **Our office cannot guarantee that your insurance provider will cover the services you receive. If your claim is denied or an alternate benefit is applied, you are responsible for the remaining balance.** Your insurance policy is a contract between you, your employer, and the insurance company. While we will assist in providing any necessary documentation, we are not responsible for disputes with your insurance carrier. If payment from your insurance provider is not received within 60 days from the date of service, the balance will become your responsibility.

PAYMENT OPTIONS: We accept the following forms of payment: Cash, check (please note: returned check fees may apply), major credit cards (please note a processing fee will be applied to credit card payments), third party financing options

PATIENT RESPONSIBILITY: I acknowledge and accept full financial responsibility for all services provided by Denver Smiles, in accordance with the applicable fees and terms. I understand that this responsibility is not dependent on whether my dental insurance pays for all, part, or none of the charges. If payment is not received within 30 days of the statement date, a service fee will be applied. Accounts that become delinquent may be referred to a third-party collection agency, and I will be responsible for all associated legal or collection fees incurred. I authorize Denver Smiles, its employees, agents, and assignees to contact me via phone, email, text message, mail, or other means regarding my account. I also authorize any collection agency and its agents to communicate with me through the same channels.

ASSIGNMENT AND RELEASE: I authorize my dental benefit provider to make payments directly to Denver Smiles. I accept financial responsibility for all services not covered by insurance. I also authorize the release of any necessary dental or medical information required by my insurance carrier to process claims.

CANCELLATION POLICY: We value your time and strive to see every patient promptly. To help us maintain our schedule and minimize disruptions a minimum of 48 business hours' notice is required for any cancellations or appointment changes. Cancellations or reschedules made with less than 48 business hours' notice—or missed appointments without notice—will incur a $75 fee, effective August 1, 2025. All cancellations or appointment changes must be made directly with our office staff during regular business hours.

I acknowledge that I have received, read, and understand the Financial Policy, Agreement, and Cancellation Policy for Denver Smiles. I understand that these policies may be updated at any time and that a copy of the revised policy will be provided upon request.

SIGNATURE AUTHORIZATION _____ DATE _____

GENERAL DENTAL INFORMATION AND CONSENT TO PERFORM DENTISTRY

1. Low Dose X-rays: Low-dose dental X-rays are an essential diagnostic tool that helps the doctor detect underlying issues and diseases not visible to the naked eye. Protective shields and lead aprons are available upon request. X-rays are required for all new patients and will be taken periodically as needed thereafter.

2. Drugs and Medication: Antibiotics, analgesics, and other medications may cause allergic reactions, which can include symptoms such as redness, swelling, pain, itching, vomiting, and in rare cases, anaphylactic shock (a severe allergic reaction).

3. Changes in Treatment: During treatment, it may be necessary to change or add procedures due to conditions discovered during the procedure that may not have been evident during the initial examination. A common example is the need for root canal therapy following a routine restorative procedure. Dental infections—including tooth decay and gum disease—can impact other areas of the body, including the heart, joints, fertility. Prompt treatment of dental infections is essential for overall health.

4. Extractions: Treatment alternatives (e.g., root canal therapy, crowns, periodontal surgery) will be discussed prior to tooth removal. Please be aware that extraction does not always eliminate existing infections, and further treatment may be required. Potential risks include pain, swelling, infection, dry socket, loss of sensation (paresthesia) in the teeth, lips, tongue, or surrounding tissues—possibly lasting indefinitely—and jaw fracture. In rare cases, referral to a specialist or hospitalization may be necessary if complications occur.

5. Crowns and Bridges: While every effort is made to match the color of natural teeth, a perfect match with artificial restorations is not always possible. Temporary crowns may come off, and it is your responsibility to ensure they remain in place until the permanent restoration is delivered. Please note: the final opportunity to make changes to the shape, size, fit, or color of the crown or bridge occurs at the preparation appointment.

6. Dentures (complete and partials): Removable prosthetic appliances include risks and possible failures. This includes gum tissue pressure, jaw ridges not providing adequate support and/or retention, excessive saliva or excessive dryness of the mouth, and general psychological and physical problems interfering with success. Breakage is possible by dropping the dentures or chewing on foods that are excessively hard. Full dentures become loose when there is a change in the gum tissues. The cost for a denture re-line is an additional fee. Any denture issues must be brought to our attention within 30 days of the final denture delivery.

7. Endodontics (Root Canal): Root canal treatment does not guarantee the tooth will be saved. Complications can include persistent infection, materials extending beyond the root. The need for additional procedures may be necessary.

8. Periodontal Disease (Gum Tissue & Bone): This is a serious and progressive condition that can result in gum and bone loss, and eventual tooth loss. Alternative treatments—including gum surgery, extractions, or tooth replacement options—will be discussed as needed. Any dental procedure may have a future adverse effect on your periodontal condition.

9. Implants: They are an alternative to bridges, partials, or dentures. This multi-step process may take several months to complete. Like crowns, implant restorations may not exactly match the color of natural teeth.

10. Sealants: These provide a protective barrier over the chewing surfaces of back teeth but do not guarantee cavity prevention. They may occasionally need replacement, as they are not permanent. We provide a 2-year warranty on sealants, provided the patient maintains biannual dental exams and cleanings. Sealants may be placed at any age, as long as the teeth are free of decay and existing fillings. The doctor will determine the appropriate timing for sealant application.

11. Sedative Fillings: Sedative fillings are temporary and are used when nerve exposure is suspected. If symptoms develop within 6–8 weeks, root canal therapy or extraction may be required. If no symptoms occur, this suggests that the nerve was not exposed. Sedative fillings help the tooth produce reparative dentin and prepare the tooth for permanent restoration at a later appointment.

I understand that this signed dental consent may be withdrawn at any time. I authorize Denver Smiles to review my existing medical records, perform examinations, and provide necessary dental care as deemed appropriate. I have carefully read and fully understand the General Dental Information provided to me, and I authorize dental treatment as needed. I also authorize the doctor to provide ongoing dental care on a continuing schedule until I choose to withdraw my consent. I acknowledge that I will be informed of any recommended restorative treatment based on examination findings. Denver Smiles will not proceed with any restorative procedures without my verbal or written consent, or that of my legal representative or Power of Attorney (POA), if applicable.

SIGNATURE AUTHORIZATION _____ **DATE** _____

Notice of Privacy Practice (HIPAA)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review this information carefully. You have the right to receive a copy of this notice

At Denver Smiles, we have always kept your information secure and confidential. A new law requires us to continue maintaining our privacy to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information in our computer.

We may share your medical information with our business associates such as billing service. We may have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information by phone, email, voicemail, and text message. We also want to call, email, or text to remind you about your appointments and other patient care related information. If you are not home, we may leave this information on your answering machine or with the person who answers the phone. If you wish to opt out to any of the methods of communication, please let a staff member know at your next appointment.

In an emergency, we may disclose your health information to a family member or another responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold your information will become the property of the new owner. Except as describes above his practice will not use or disclose your health information without written authority.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail or email your files to you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding information you want to see. If you also want a copy of your records, we may charge a reasonable fee for the copies. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the department of health and human services; 200 independence Ave. S.W. RM 509f, Washington DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint please contact our private office, Denver Smiles at 303-623-4444. This notice has been in effect since April 14, 2003.

SIGNATURE ACKNOWLEDGEMENT _____ DATE _____

Denver Smiles
Personalized Dentistry

RECORDS RELEASE FORM

Patient Full Name:_____

Birthdate:_____

Previous Dental Office:_____

Phone, Fax, Email _____

_____

_____

RELEASE TO: Denver Smiles
PHONE: 303-623-4444 | **Fax:** 303-623-0443
EMAIL: hello@denversmiles.com
ADDRESS: 8015 West Alameda Avenue Suite 115
Lakewood, CO 80226

INFORMATION REQUESTED

☐Copy of dental chart
☐Copy of dental radiographs
☐Other : _____

PURPOSE FOR WHICH INFORMATION IS TO BE USED

☐Transfer of records/ Changing Doctor
☐Second opinion
☐Specialist
☐Other: _____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____ _____

PATIENT OR LEGAL GUARDIAN DATE

_____ _____

WITNESS DATE

_____ _____

DOCTOR DATE