Welcome to Monument Dental!

Please complete the new patient forms and have them with you for your first appointment.

Today's Date _____/_____/_____

Monument Dental
Marcus Bellamy DMD

How did you hear about us? ☐ Direct mail ☐ Internet ☐ Referral _____

Patient Information

Name _____ Phone _____

Address _____ City/State/Zip _____

How long at current address? _____ SSN _____

Birth Date _____/_____/_____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Separated ☐ Married ☐ Widowed ☐ Divorced ☐ Dependant

Employment Information

Employer _____ Work Phone _____

Occupation _____ How long at current job? _____

Insurance Information

Insurance Provider _____ Phone _____

Address _____ City/State/Zip _____

Insured's Employer _____ Insured's Name _____

Relationship to Patient _____ Insured's SSN or Member # _____

Policy or Group # _____ Other Insurance Info _____

Responsible Party *(If other than patient)*

Relationship to patient _____ Name _____

Address _____ City/State/Zip _____

How long at current address? _____ Phone _____

SSN _____ ☐ Male ☐ Female Birth Date _____/_____/_____ Age _____

Please Check All Dental Concerns That Apply To You:

TEETH:

- ☐ Broken or Chipped
- ☐ Crooked
- ☐ Decay
- ☐ Difficulty Chewing
- ☐ Discolored
- ☐ Food Trap Areas
- ☐ Grinding or Clenching
- ☐ Loose/Missing Filling
- ☐ Loose Tooth or Teeth
- ☐ Mouth Sores
- ☐ Sensitive to Hot/Cold
- ☐ Sensitive to Sweets
- ☐ Tooth Pain

GUMS:

- ☐ Bleeding
- ☐ Pimple or Bump
- ☐ Sore or Sensitive
- ☐ Chronic Dry Mouth

JAW / FACIAL PAIN PROBLEMS:

- ☐ Facial Pain
- ☐ Jaw Pain
- ☐ Jaw Clicks
- ☐ Frequent Headaches
- ☐ Pain in Cheeks or Temples

Other concerns or reason for visit: _____

☐ I am here for a periodic examination, no specific known problems.

Past Dental History:

Last Visit _____ Frequency of Dental Visits _____ Months _____ Years _____ As Needed

☐ Have tooth replacements such as dentures, partials, bridges or implants? ☐ Dissatisfied ☐ Satisfied

Other _____

Patient Information Cont.

LIST ANY MEDICATIONS I SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

☐ Antibiotics ☐ Sedatives ☐ Aspirin ☐ Metals ☐ Codeine
☐ Novocaine ☐ Local Anesthetics ☐ Sleeping Pills ☐ Sulfa Drugs ☐ Iodine
☐ Penicillin ☐ Latex ☐ Plastic ☐ Other _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

☐ Antibiotics ☐ Anticoagulants ☐ Blood Thinners ☐ Blood Pressure ☐ Codeine
☐ Cortisone ☐ Muscle Relaxants ☐ Diet Pills ☐ Pain Medication ☐ Digestive Aids
☐ Sleeping Pills ☐ Heart Medication ☐ Tranquilizers ☐ Insulin ☐ Other _____

MEDICAL HISTORY:

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer
☐ Current Pregnancy ☐ Depression ☐ Diabetes ☐ Headaches
☐ Heart Murmur ☐ Cuts Bleed Easily ☐ Hepatitis ☐ Dizziness
☐ Digestive Problems ☐ Epilepsy or Seizures ☐ Heart Pacemaker ☐ Heart Palpitations
☐ Kidney Problems ☐ Liver Problems ☐ Low Blood Pressure ☐ Osteoporosis
☐ High Blood Pressure ☐ Radiation Treatment ☐ Respiratory Problems ☐ Rheumatic Fever
☐ Scarlet Fever ☐ Sinus Problems ☐ Tuberculosis ☐ Heart Valve Damage
☐ Tobacco User ☐ Artificial Joint/Prosthetic ☐ Immune System Disorder ☐ Heart Valve Replacement
☐ Injury to: ☐ Face ☐ Mouth ☐ Neck ☐ Teeth ☐ Other _____

DESCRIBE ANY SERIOUS ILLNESS, MAJOR SURGERY OR CONDITIONS NOT LISTED ABOVE:

mm/yy: /_____ _____

mm/yy: /_____ _____

mm/yy: /_____ _____

mm/yy: /_____ _____

ARE YOU UNDER A PHYSICIANS CARE?

Practitioner Specialty Treatment & Approx. Date

_____

_____

Primary Care Physician _____

IF VISIT IS DUE TO ACCIDENT, PLEASE DESCRIBE:

_____

_____

I authorize the release of a full report of examination findings, diagnosis. treatment program, etc., to any referring or treating dentist or physician, I additionally authorize the release of any medical information to insurance companies or (or legal documentation. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Signed _____ Date_____/_____/_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Linda Tronnes. Office Manager

Telephone: 719-488-2721

Address: P.O. Box 1649, 236 Washington Street, Monument. CO 80132

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.