ALTITUDE DENTAL

FAMILY DENTISTRY | PROSTHODONTICS | DENTAL IMPLANTS | COSMETIC DENTISTRY

Welcome to Our Office!

Our team looks forward to bringing you into our family of patients. Please help us meet all your dental needs by completing this form. If you have any questions or need assistance, please ask us – we will be happy to help.

Please complete the following confidential information:

Dr./Mr./Mrs./Ms./Miss Name: _____ Date of Birth: _____

SS#: _____ Employer: _____ Preferred Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

How did you hear about us? _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Note: Please present your driver's license for us to photocopy and keep within your file. Thank you.

Driver's License State: _____ Number: _____

Consent for Treatment

1. I hereby authorize Altitude Dental or designated staff to take x-rays, study models, photographs, and any other diagnostic procedures needed for Dr. Rolfes to make a thorough diagnosis of _____'s dental needs.

(Name of Patient)

2. Upon such diagnosis, I authorize Altitude Dental to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication, as necessary. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for an explanation of any possible complications.

Patient: _____ Date: _____

Parent or Responsible Party Signature: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury _____	☐	☐
2.	an allergic or bad reaction to any of the following:	☐	☐
	○ aspirin, ibuprofen, acetaminophen, codeine _____		
	○ penicillin _____		
	○ erythromycin _____		
	○ tetracycline _____		
	○ sulfa _____		
	○ local anesthetic _____		
	○ fluoride _____		
	○ chlorhexidine (CHX) _____		
	○ Iodine _____		
	○ metals (nickel, gold, silver, _____)		
	○ latex _____		
	○ nuts _____		
	○ fruit _____		
	○ milk _____		
	○ red dye _____		
	○ other _____		
3.	heart problems, or cardiac stent within the last six months _____	☐	☐
4.	history of infective endocarditis _____	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6.	pacemaker or implantable defibrillator _____	☐	☐
7.	orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8.	heart murmur, rheumatic or scarlet fever _____	☐	☐
9.	high or low blood pressure _____	☐	☐
10.	a stroke (taking blood thinners) _____	☐	☐
11.	anemia or other blood disorder _____	☐	☐
12.	prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13.	pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14.	chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15.	breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16.	sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17.	kidney disease _____	☐	☐
18.	liver disease or jaundice _____	☐	☐
19.	vertigo (e.g. "the room is spinning") _____	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21.	hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22.	high cholesterol or taking statin drugs _____	☐	☐
23.	diabetes (HbA1c = _____) _____	☐	☐
24.	stomach or duodenal ulcer _____	☐	☐
25.	digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐
26.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27.	arthritis or gout _____	☐	☐
28.	autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29.	glaucoma _____	☐	☐
30.	contact lenses _____	☐	☐
31.	head or neck injuries _____	☐	☐
32.	epilepsy, convulsions (seizures) _____	☐	☐
33.	neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _	☐	☐
34.	viral infections and cold sores _____	☐	☐
35.	any lumps or swelling in the mouth _____	☐	☐
36.	hives, skin rash, hay fever _____	☐	☐
37.	STI/STD/HPV _____	☐	☐
38.	hepatitis (type ____) _____	☐	☐
39.	HIV/AIDS _____	☐	☐
40.	tumor, abnormal growth _____	☐	☐
41.	radiation therapy _____	☐	☐
42.	chemotherapy, immunosuppressive medication _____	☐	☐
43.	emotional difficulties _____	☐	☐
44.	psychiatric treatment or antidepressant medication _____	☐	☐
45.	concentration problems or ADD/ADHD _____	☐	☐
46.	alcohol/recreational drug use _____	☐	☐

ARE YOU:

		YES	NO
47.	presently being treated for any other illness _____	☐	☐
48.	aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49.	taking medication for weight management _____	☐	☐
50.	taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51.	often exhausted or fatigued _____	☐	☐
52.	experiencing frequent headaches or chronic pain _____	☐	☐
53.	a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54.	considered a touchy/sensitive person _____	☐	☐
55.	often unhappy or depressed _____	☐	☐
56.	taking birth control pills _____	☐	☐
57.	currently pregnant _____	☐	☐
58.	diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)**

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐

BITE AND JAW JOINT	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? _____	☐	☐
34. Have you ever bleached (whitened) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Consent for Release of Use and Disclosure of Protected Health Information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. These rights have been outlined in our office's Notice of Privacy Practices (NOPP).

I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated consent shall be as effective as the original. I release the practice, its employees, and agents for any and all disclosures as stated in the NOPP.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations and super-confidential information. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I hereby authorize Dr. Denise Pieczynski to use and disclose any necessary information from my dental record, verbally, faxed, emailed or by mail, in accordance with our Notice of Privacy Practices.

_____ _____

Print Full Name Date

_____

Signature

Social Media Consent / Release Form
For News Media, Promotional Materials, Written Articles, Research and/or Photographs

I hereby authorize Altitude Dental to use my photo and/or information related to my experiences with their office. I understand this information may be used in publications, including electronic publications, audiovisual presentations, promotional literature, advertising, community presentations, letters to area legislators and media and/or other similar ways. The office of Altitude Dental will disclose to me or my legal representative, where appropriate, the specific information and/or photo to be used prior to release in the social media.

My consent is freely given as a public service to the office of Altitude Dental, without expecting payment. I release the office of Altitude Dental and their respective employees, officers, and agents from any and all liability which may arise from the use of such news media stories, promotional materials, written articles, videotape and/or photographs.

I prefer that:

☐ My complete name be used
☐ My first name only be used
☐ No name be used

I understand that I can revoke this release any time in writing and that the use of any of my photos or other information authorized by this release will immediately cease.

Please print or type:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

The signature of a parent of legal guardian is required if the above individual is under the age of 18 or in not competent.

Financial Information

Thank you for choosing Altitude Dental. We are committed to providing you a comfortable, relaxed experience, as well as the best oral health care provided anywhere. **Your clear understanding of our financial policy is important to our professional relationship, so we ask that you read, initial as indicated, and sign**.

Payment is due at the time of service. If your treatment requires special payment arrangements, our financial coordinator will be happy to work this out with you prior to beginning your treatment. We accept: **Cash, Check, MasterCard, Visa, Discover, American Express, Debit Cards, and CareCredit.**

Person Financially Responsible for the Account:

Name: _____ Relationship to Patient: _____

Address: _____

Phones: H/_____W/_____C/_____

Date of Birth: _____ Social Security #: _____

Insurance Coverage:
Do you have dental insurance? YES: _____ NO: _____ (Skip to #6)

We will file your insurance as a courtesy to you; however, we do not take it as a form of payment. **Payment is due at the time of service.** If you have insurance, please provide us with your card, as well as your driver's license or other form of identification with a photo ID. To assure your information is always current and accurate, please report any changes in personal information or insurance changes. **1) Initial:** _____

We make no claim to know what services your insurance plan covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility to know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions regarding covered services. In addition, be aware that some of the services may not be covered services by your insurance. All charges are your responsibility. **2) Initial: _____**

Insurance Claims Processing:
The office will supply factual information to facilitate claim processing. Your insurance policy is a contract between you and your insurance company.
3) Initial: _____

Out of Network and PPO Plans:
We are considered out of network for all plans. We are happy to bill your insurance company as a courtesy to you, but payment is due at the time of service. **4) Initial: _____**

Patient Release for Records:
I hereby authorize Altitude Dental to release to my insurance company any necessary information needed to file and expedite
payment on my claim. **5) Initial: _____**

Returned Checks:
There will be a $25.00 charge for all bank returned checks. If a second check is presented and returned, we will require future payments to be made by cash or credit card. **6) Initial: _____**

Patient Payment:
I have read, understand, and abide to the terms stipulated above. I have requested clarification of any parts or parts of this financial agreement that I do not understand. I agree to be fully responsible for total payment of procedures performed in this office. I agree that should this account be referred to an attorney or agency for collection, I will be responsible for all collection costs, attorney fees, and court costs. I, the undersigned, have read the above and assume the responsibility for my account.
7) Initial: _____

Patient Name: _____ Date: _____

_____

Signature of Person Financially Responsible for this Account