JAMES
BIENEMAN, D.D.S.
303-797-0832 www.bienemandentistry.com
6650 South Vine Street, Suite 220, Centennial, CO 80121

Patient Registration

Patient's Name: Date of Birth:

Home address:

City: State: Zip:

Home Phone. # Cell Phone. #

Your Employer: Work Phone. #

Soc. Security #: **E-mail address:**

Male Female Marital Status: Single Married Widow Separated

Are you a full time student?

If patient is a minor, we need: Mother's DOB: Father's DOB:

Responsible Party Name:

Relationship: Spouse's/Parent's Phone #:

Emergency Contact name, address and telephone of a relative not living with you:

How did you hear about our office?

Dental Insurance information (Primary)	If you have secondary insurance
Insured's Name:	Insured's Name:
Insured's Employer:	Insured's Employer:
Insurance Company:	Insurance Company:
Insurance Phone#:	Phone #:
DOB:	DOB:
SS#:	SS#:
Group #:	Group #:
ID number#:	ID number#:

Patient's Signature (Parent if a minor) **Date**

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Name ________________

Primary care Physician ________________
Do you use tobacco? If so how often? ________________
Do you take controlled substances? ________________
Do you need to pre-medicate? ________________
Do you snore? ________________
Have you ever been diagnosed with sleep apnea? ________________
Do you have jaw joint pain, grinding or clenching your teeth? ________________
Have you ever had a serious head or neck injury? ________________

Are you allergic to any of the following?

Aspirin	Acrylic	Local Anesthetics
Penicillin	Metal	Other: ________________
Codeine	Latex	________________

Have you ever taken the following medications?

Actonel	Aredia	Bisphosphonates
Fosamax	Reclast	Phen-Fen
Zometa	Boniva	Redux

Women:
Are you Pregnant/Trying to get pregnant? ________________
Taking oral contraceptives? ________________
Nursing? ________________

Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	◯	◯	Hemophilia	◯	◯	Renal Dialysis	◯	◯	Alzheimer's Disease	◯	◯
Hepatitis A	◯	◯	High Blood Pressure	◯	◯	Anaphylaxis	◯	◯	Drug Addiction	◯	◯
Hepatitis B or C	◯	◯	Artificial Heart Valve	◯	◯	Herpes	◯	◯	Cold Sores/Fever Blisters	◯	◯
Emphysema	◯	◯	Excessive Bleeding	◯	◯	Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯
Sickle Cell Disease	◯	◯	Excessive Thirst	◯	◯	Artificial Joint	◯	◯	Hypoglycemia	◯	◯
Sinus Trouble	◯	◯	Kidney Problems	◯	◯	Convulsions	◯	◯	Irregular Heartbeat	◯	◯
Asthma	◯	◯	Blood Transfusion	◯	◯	Stroke	◯	◯	Stomach Disease	◯	◯
Leukemia	◯	◯	Frequent Headaches	◯	◯	Anemia	◯	◯	Liver Disease	◯	◯
Swelling of Limbs	◯	◯	Breathing Problem	◯	◯	Diabetes	◯	◯	Low Blood Pressure	◯	◯
Thyroid Disease	◯	◯	Bruise Easily	◯	◯	Lung Disease	◯	◯	Radiation Treatments	◯	◯
Cancer	◯	◯	Mitral Valve Prolapse	◯	◯	Tuberculosis	◯	◯	Chemotherapy	◯	◯
Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯	Chest Pains	◯	◯	Heart Attack/Failure	◯	◯
Ulcers	◯	◯	Angina	◯	◯	Heart Murmur	◯	◯	Fainting Spells/Dizziness	◯	◯
Psychiatric Care	◯	◯	Heart Pace Maker	◯	◯	Tonsillitis	◯	◯	Congenital Heart Disorder	◯	◯

Other conditions: ________________

Current medications: ________________

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

When was the last time you saw a dentist and what was done?
____

If I could change my smile, I would:

- Make it more white ◯
- Make it straighter ◯
- Close the spaces ◯
- Replace the black metal filling with tooth colored restorations ◯ ◯
- Repair chipped teeth ◯
- Replace old crowns that don't match ◯
- Replace missing teeth ◯
- Have a smile makeover ◯
- Botox ◯
- Juvederm/Facial Fillers ◯

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient signature (Parent if child) ________________ **Date** ________ **Dentist Signature** ________________

Sleep Health Assessment

Name ____________________

Recently, how likely are you to doze off or fall asleep in the following situations, in contrast to simply feeling tired?

Choose a number for each situation:	**No Chance of Dozing**		**High Chance of Dozing**	
Watching TV	0	1	2	3
Sitting and reading	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Sitting inactive in a public place (a theater or meeting)	0	1	2	3
Lying down in the afternoon when circumstance permit	0	1	2	3

Select any condition you have been treated for or use:

- ○ High Blood Pressure
- ○ Heart Disease
- ○ Diabetes
- ○ Lung Disease
- ○ Insomnia
- ○ Narcolepsy
- ○ Sleeping Medication
- ○ Stroke
- ○ Depression
- ○ Sleep Apnea
- ○ Nasal Oxygen Use
- ○ Restless Leg Syndrome
- ○ Morning Headaches
- ○ Pain Medication (Vicodin, OxyContin)

Other Conditions: ____

To the best of my knowledge, the questions on this form have been accurately answered.
I understand that providing incorrect information can be dangerous to my (or patient's) health.
It is my responsibility to inform the dental office of any changes in medical status.

____

Patient signature (Parent if child) **Date**

____

Dentist Signature

Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.
Checks that are returned to our office from your financial institution are subject to a $20.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available through CareCredit upon request and approval.

You will have to take responsibility for any fees your insurance has not covered after 60 days. Any expenses incurred in collecting a past due account will be turned over to a collection agency after 90 days which can include attorney fees.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: ____________________________________ Date: ___________________
Print name __________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, ______________________________________, have read or received a copy of this office's Notice of Privacy Practices**. (Copy is in black book on the table in our waiting area or on our website under "Forms")**

____
{Please Print Name}

______________________________________ ______________________________
{Signature} Guardian Signature

____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself. By signing this, you also allow us to release information to any referring doctor or specialist.

I, ______________________________________, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

______________________________________ ___________________________
{Please Print Name} Relationship

______________________________________ ___________________________
{Please Print Name} Relationship

______________________________________ ___________________________
{Please Print Name} Relationship

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)

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