Patient Information

Patient Name: ______________________________ ________
Last First MI Nickname

Social Security #: ______________ Date of Birth: ______________

Driver's License # ______________

Please Circle One: Married Single Child Other

Address: ______________________________
Street Apt #

____
City State Zip Code

Mobile: __________ Home: __________ Work: __________

Email: ______________________________

Health Information

Date of Last Dental Visit: __________ Reason for Today's Visit: __________

Have you ever had the following:

- AIDS
- Allergies ________ ________
- Anemia
- Arthritis
- Artificial Joints
- Asthma
- Blood Disease
- Cancer
- Diabetes
- Dizziness
- Epilepsy
- Excessive Bleeding
- Fainting
- Glaucoma
- Growths
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Mental Disorders
- Nervous Disorders
- Pacemaker
- Pregnancy
  Due Date ________
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems
- Stroke
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease
- Codeine Allergy
- Penicillin Allergy
- Other: ________ ________ ________

PLEASE ATTACH LIST OF MEDICATIONS

- Do you use tobacco? ☐ Yes ☐ No If so, how often? __________
- Do you use marajuana? ☐ Yes ☐ No If yes, how often? __________
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________

Name of Physician: ______________________ Phone: __________

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, Please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any changes in my health, I will inform my doctors at the next appointment without fail.

______________________________ Date: __________
Signature of patient, parent or guardian

How did you hear about our office?

- Patient, friend ________
- Yelp
- Facebook
- Google
- School
- Patient, relative ________
- Next Door
- Work
- Dental Office ________
- Other ________

Spouse or Responsible Party Information

Please fill out this section if it is different from Patient Information

The following is for: ☐ The Patient's Spouse ☐ The Person Responsible for Payment Patient's Name: ____________

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security # ____________ Birth Date: ____________

Home #: ____________ Mobile #: ____________ Work #: ____________

Address: ____

Street Apt #

____

City State Zip Code

Employment Information

The following is for: ☐ The Patient ☐ The Person Responsible for Payment

Employer Name: ____________ Occupation: ____________

Address: ____

Street City State Zip Code Phone #

Insurance Information

Primary

Name of Insured: ______________________ Is Insured a Patient? ☐ Yes ☐ No

Last First MI

Insured Date of Birth: ____________ ID# ____________ Group # ____________

Insured Address: ____

Street City State Zip Code

Insured Employers Name: ____

Address: ____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address: ____

____

Secondary:

Name of Insured: ______________________ Is Insured a Patient? ☐ Yes ☐ No

Last First MI

Insured Date of Birth: ____________ ID# ____________ Group # ____________

Insured Address: ____

Street City State Zip Code

Insured Employers Name: ____

Address: ____

Street City State Zip Code

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address: ____

____

DR. CAMERON AUGER & ASSOCIATES
19245 E SMOKY HILL ROAD, SUITE B
CENTENNIAL, CO 80015
PHONE: 303-680-3308
FAX: 303-680-3928

Billing and Collection Policies

We bill insurance companies for you as a courtesy. Our billing your insurance does not guarantee payments. Insurance companies may deny payment due to waiting periods, frequency limitations from previous work done on a tooth (ex. five-year crown rule) or area of the mouth, or for procedures not covered due to insurance riders in your plan. **Our office is unable to verify all possible exceptions to your insurance plan.**

We appreciate co-payments at the time of service. Our computer program makes an estimate based on past billings and information provided by the insurance company. Any fees not covered by the co-payment will be billed to the patient. Any overpayments will be returned to the patient promptly. **Any estimate given by Dr. Auger, associate dentists or a staff member is only an estimate** based on information given by **your insurance company**. Information from insurance is given in general categories and is not specific to every procedure. **Estimates are not a guarantee of payment** by your insurance company. As a patient, you are welcome to verify directly with your insurance company or request a pre-authorization be sent.

As the patient, you have the responsibility for payment for all services provided. As the patient, you are responsible for co-payments associated for all procedures provided. We send out monthly statements. If not paid promptly, the account will be turned over to our collection agency.

We understand patients schedules occasionally change, and you will need to reschedule or cancel an appointment. Please contact the office at least 48 business hours prior to your scheduled appointment to cancel or reschedule the appointment to avoid a missed appointment fee.

We do not place amalgam fillings. Some insurance companies will downgrade payments for posterior composite restorations. Any downgrading of payment by the insurance company is your responsibility.

Please call with any questions regarding your account. We will answer questions as promptly as possible.

DATE: __________

Printed Name:

______________________________ ______________________________

Last, First, Middle Initial Signature of patient or guardian

General Consent

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. Drug or chemical reaction. Dental materials and medication may trigger allergic or sensitivity reactions.
2. Long-term numbness (parasthesia). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. Sensitivity in teeth or gums, infection, or bleeding.
5. Swallowing or in inhaling small objects.

While we follow procedural guidelines which almost often lead to a clinical success, just like in any other pursuit in healthcare, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

Please note: We do not cover amalgam restorations. Any subsequent charges for resin restorations not covered by the insurance company will be the responsibility of the patient.

I have read and understand the statements on this page.

_______________________________ _______________

Patient's signature Date

_______________________________ _______________

Parent's signature (if patient is a minor) Date