Today's Date: _____

Name: _____ Date of Birth: _____
First Middle Last

Residence: _____
Street City Zip Code Home Phone Number

Social Security: _____-____-_____ e-mail: _____

Employment: _____
Position Employer Work Phone Number

Marital Status: (Please Circle) Single Married Separated Divorced

Spouse's Name: _____ Date of Birth: _____
First Middle Last

Employment: _____
Position Employer Work Phone Number

Social Security: _____-____-_____ e-mail: _____

How would you like us to contact you? _____

Referred By: _____

Why did you choose Dr. Gilmore's Office?

- ❑ Cosmetic Dentistry Focus
- ❑ Comprehensive Dentistry
- ❑ Special Services Offered
- ❑ Other: _____

When is the most convenient time for dental appointments?

- ❑ Early Morning
- ❑ Lunch
- ❑ Afternoon
- ❑ Late Afternoon

How would you like to pay for your professional services?

- ❑ Cash/Check
- ❑ Credit Cards

What is the reason for your visit today?

- ❑ New Patient Examination
- ❑ Consultation
- ❑ Cleaning
- ❑ Emergency

If you have dental benefit insurance, please complete the backside of this form.

Dental Benefit Insurance Information

As a courtesy, we are happy to process insurance claims for you. Your deductible and estimated co-pay is due at the time of service. Please fill out the following information and sign the following release.

Primary Information: (Please Print)

Subscriber's Name: _____
First Middle Last

Patient's Relationship to Subscriber: (Please Circle) Self Spouse Child

Social Security: ____-____-_____ Date of Birth: _____

Subscriber's Home Address: _____
Street City State Zip Code

Employer Company Name: _____

Dental Insurance Company: _____ Group #: _____

Address of Insurance Company: _____
Street City State Zip Code

Phone Number of Insurance Company: _____

Secondary Information:

Subscriber's Name: _____
First Middle Last

Patient's Relationship to Subscriber: (Please Circle) Self Spouse Child

Social Security: ____-____-_____ Date of Birth: _____

Subscriber's Home Address: _____
Street City State Zip Code

Employer Company Name: _____

Dental Insurance Company: _____ Group #: _____

Address of Insurance Company: _____
Street City State Zip Code

Phone Number of Insurance Company: _____

I authorize release of any information relating to insurance claims. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Dr. Shauna Gilmore of the insurance benefits otherwise payable to me.

_____ _____
Signed (Insured Person) Date

Name:_____

Health Questionnaire

Name of Medical Doctor: _____ Date of Last Visit: _____

Please list any medications you are now taking: _____

_____

Yes No Are you allergic to any medications or materials? (Please circle allergies below)

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

Have you ever had: (Please circle Yes or No for each line)

Yes No Rheumatic Fever

Yes No Heart Condition -- Mitral Valve Prolapse, Heart Attack, Angina, Heart Attack, High Blood Pressure, Low Blood Pressure, Stroke or Chest Pain

Yes No Artificial Joint -- If yes, which joint? _____

Yes No Respiratory Problems -- Asthma, Tuberculosis, Sinus Problems or Hay Fever

Yes No Epilepsy, Convulsions or Fainting Spells

Yes No Anemia or Bleeding Disorder

Yes No Jaundice or Kidney Disease

Yes No Hepatitis or Liver Disease

Yes No Stomach/Intestinal Disease or Ulcers

Yes No Arthritis, Gout, Rheumatism, or Cold Sores

Yes No Mental, Psychiatric or Psychological Problems

Yes No Drug or Alcohol Addiction

Yes No Hearing Impairment

Yes No Do you use tobacco products? How much? _____

Do you have any disease, condition, or problem not listed above that you think I should know about? _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform Dr. Gilmore or her staff at the next appointment without fail.

Shauna Gilmore, DDS, PC
Family & Cosmetic Dentistry
"Enhancing Smiles - Enhancing Lives"

Name:_____

X _____ Date: _____

Dental History

What are your current dental concerns? _____

Do you have dental examinations on a routine basis? _____

When was your last visit to a Dentist? _____

Have you ever had an oral cancer screening? _____

If you could change your smile in any way, what would you change?

_____

Do your gums ever bleed? _____

Have you ever had periodontal disease or gingivitis? _____

What is your routine for brushing and flossing? _____

Are any of your teeth painful or sensitive to hot, cold, pressure or sweets?

_____

Do you have any cavities or areas of decay? _____

Do you have any concerns about your breath? _____

Do you have any missing teeth? _____

Does your jaw "pop" or "click" when opening wide?

_____

Do you grind or clench your teeth while awake or asleep?

_____

Are there wear areas on your teeth? _____

Have you ever had study models made of your teeth? _____

Do you have any other questions regarding your oral health? _____

_____

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient's Name: _____

Patient's Address: _____

_____

Patient's Phone: _____

Release From: Dr. Name: _____

Address: _____

_____

Phone: _____

I request and authorize _____ to release the information specified below to Shauna Gilmore, D.D.S. P.C. Please send to Dr. Gilmore by email (info@drsgilmore.com), fax (303-225-7575) or U.S. Mail (6881 S Holly Circle – Suite 206, Centennial, CO 80112).

INFORMATION REQUESTED:

_____ X-Rays

_____ Copy of Perio Chart

_____ Patient History

_____ Other: _____

PURPOSE or NEED FOR WHICH INFORMATION IS TO BE USED:

_____ Transfer of Records

_____ Second Opinion

_____ Other: _____

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

_____ Patient's Name (print)

_____ Name of person authorized to sign for patient (print)

_____ Patient's Signature

_____ Signature of Authorized Person

_____ Date

_____ Date

Shauna Gilmore, D.D.S., P.C.

6881 S Holly Circle #206 Centennial CO, 80112 (303) 335-7575

Financial Policy

We are committed to providing you with exceptional dental care. We realize that your oral health is an investment, and we are pleased to offer you the following payment options.

Please check one of the following:

___**Cash or Personal Check**

___**Personal Credit or Debit Cards**
(Mastercard, Visa, Discover, American Express, or Tradebank International)

___**Prepayment**
We are happy to offer a 5% courtesy for cash or check, or a 3% courtesy for credit card payments of $1000.00 or more, when prepaid in full upon scheduling your appointment.

___**Monthly Installments**
We will accept 50% of your payment at time of service, then divide the remaining balance into thirds.

___**Care Credit**
We work with Care Credit, an outside financing company that provides a healthcare credit card to our patients for fixed low minimum monthly payments.

As a courtesy for patients with dental insurance, we are happy to submit insurance claims on your behalf and maximize your benefits. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company. I understand that I am responsible for all costs of dental treatment.

In the event, my account should become more that 60 days late, I understand that my account will be charged one and one-half percent (1.5%) per month interest (i.e. 18% per year). Any account considered 90 days late may be referred to a collection agency. There will be a $250 service charge added to all accounts referred out for collections. In the event legal action is taken, I agree to be responsible for all attorney fees and other court costs.

Missed Appointments

Appointment times are reserved especially for you. If you come in late, Dr. Gilmore may request that you reschedule the appointment. You will be charged a fee of $75. If for any reason you should need to change your appointment, there will be no charge provided you give us 48-hour notice. Please help us serve you better by keeping your scheduled appointments.

_____ _____

Signature Date Dental Office Coordinator Date

Shauna Gilmore, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

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