Shauna Gilmore, DDS

Name _____
Title First Middle Last

Home Address: _____
Street

_____
City State Zip Code

Date of Birth: _____ Social Security: _____

Employment: _____
Position Employer

May we have permission to leave a message at the numbers listed below? (Please Check) ☐ Yes ☐ No

How would you like us to contact you? Please rank in order of preference:

(1,2,3,4,5)

_____ Text

_____ Cell Phone (_____)_____

_____ Home Phone (_____)_____

_____ Work Phone (_____)_____

_____ E-mail _____

Emergency Contact Name: _____ (_____)_____
Phone Number

Marital Status: (Please Check) ☐ Single ☐ Married ☐ Separated ☐ Divorced

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

Spouse's Employment: _____ (_____)_____
Position Employer Phone Number

How did you hear about us? _____

Why did you choose Dr. Gilmore's Office?

☐ Cosmetic Dentistry Focus ☐ Holistic Philosophy

☐ Comprehensive Dentistry ☐ Other: _____

I accept responsibility for payment of services. If you have dental benefit insurance, please complete the backside of this form.

_____ _____
Signature Date

6881 S. Holly Circle, Suite 206 • Centennial, Colorado 80112
303-225-7575 • www.drsgilmore.com • info@drsgilmore.com • Fax 720-529-1376

Shauna Gilmore, DDS

Dental Benefit Insurance Information

As a courtesy, we are happy to provide a billing service for your insurance claims. Your deductible and estimated co-pay is due at the time of service. Your insurance policy is a contract between you, your employer, and the insurance company. Please fill out the following information and sign the release.

Primary Information: (Please Print)

Subscriber's Name: _____
First Middle Last

Patient's Relationship to Subscriber: (Please Check) ☐ 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 Check) ☐ 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 hereby authorize payment directly to Shauna Gilmore, DDS, PC for the insurance benefits otherwise payable to me. I understand that my insurance claims will be sent electronically.

_____ _____
Signature (Insured Person) Date

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Shauna Gilmore, DDS

Medical History

Name: _____

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

Please list your medications, supplements and CBD products: _____

_____

_____

Medical History - Please mark [X] next to your response indicating if you have or have had any of the following.

Allergies
- ☐ Antibiotics *(Penicillin/Clindamycin)*
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Opioids/Codeine
- ☐ Metals
- ☐ NSAIDs (Aspirin/Ibuprofen)
- ☐ Other: _____

Artificial Joints
- ☐ Hip
- ☐ Knee
- ☐ Other: _____

Autoimmune
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Rheumatoid Arthritis

Cancer

Type:_____
- ☐ Chemotherapy
- ☐ Radiation Therapy

Cardiovascular

(Heart and Blood Vessels)
- ☐ Angina (chest pain)
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Artificial Heart Valve
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke

Endocrine

(Glands and Hormones)
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Other: _____

Gastrointestinal

(Digestion)
- ☐ Acid Reflux / GERD
- ☐ Innitive Bowel Syndrome
- ☐ Other: _____

Hearing
- ☐ Hearing Impairment

Hematologic/Lymphatic

(Blood and Lymph)
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easy
- ☐ Excessive Bleeding

Musculoskeletal

(Muscles and Bones)
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other: _____

Neurological

(Mental and Nerves)
- ☐ Depression
- ☐ Dizziness/Fainting
- ☐ Drug/Alcohol Addiction
- ☐ Seizures
- ☐ Other: _____

Respiratory

(Breathing/Lungs)
- ☐ Asthma
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Emphysema
- ☐ Sinus Problems
- ☐ Other: _____

Sleep Concerns
- ☐ Daytime Drowsiness
- ☐ Mouth Breathing
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Waking Up Frequently

Social
- ☐ Alcohol
- ☐ Drug Use
- ☐ Marijuana
- ☐ Vaping
- ☐ Tobacco

Viral Infections
- ☐ AIDS
- ☐ Hepatitis A/B/C
- ☐ HIV
- ☐ HPV

Women
- ☐ Birth Control Pills
- ☐ Currently Pregnant
- ☐ Nursing
- ☐ Hormone Replacement Therapy (HRT)

Do you have any other disease condition or problem that I should know about? _____

_____

To the best of my knowledge, the preceding answers are correct. If I have any changes in my health status or medications, I shall inform Dr. Gilmore or her team members at my next appointment without fail.

Signature: _____ Date: _____

Shauna Gilmore, DDS

Dental History

Name: _____

Date of Last Dental Visit: _____

What are your current dental concerns? _____

_____

What and how often is your routine for brushing and flossing? _____

_____

Do you use an electric toothbrush or water flosser? _____

If you could change your smile, what would you change? _____

_____

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10

Please mark (X) on any conditions which apply to you.

Pain/Discomfort

- ☐ Sensitivity (hot, cold, sweets)
- ☐ Pressure
- ☐ Broken Teeth/Fillings
- ☐ Dry Mouth
- ☐ Sores in Mouth

Appearance

- ☐ Chipped Teeth
- ☐ Crooked Teeth
- ☐ Discolored Teeth
- ☐ Misshaped Teeth
- ☐ Missing Teeth
- ☐ Overbite
- ☐ Spaces between Teeth
- ☐ Underbite
- ☐ Worn or Flat Teeth

Function

- ☐ Bad Bite
- ☐ Difficulty Opening or Closing
- ☐ Difficultly Chewing on either side
- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ) Pain
- ☐ Jaw Joint (TMJ) Clicking or Popping
- ☐ Mouth Breathing
- ☐ Speech Impediment
- ☐ Sore Muscles (neck, shoulders)

Periodontal (Gum) Health

- ☐ Bleeding, Swollen, Irritated Gums
- ☐ Bad Breath
- ☐ Loose, Tipped, Shifting Teeth
- ☐ Previous Perio/Gum Disease

Habits

- ☐ Cheek Biting
- ☐ Chewing on Ice
- ☐ Chewing on Objects
- ☐ Nail Biting
- ☐ Thumb Sucking

Comfort Options

- ☐ Nitrous Oxide *(Laughing Gas)*
- ☐ Nu Calm
- ☐ Anti-Anxiety Medicine
- ☐ IV Sedation
- ☐ Headphones
- ☐ Neck Pillow
- ☐ Paraffin Hand Softening
- ☐ Weighted Blanket

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

_____

_____

_____

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Shauna Gilmore, DDS

Financial Policy

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

1. **Cash & Check** – Please make checks payable to Shauna Gilmore, DDS, PC
2. **Credit Cards** – Visa, Mastercard, Discover, and AMEX
3. **Interest Free Financing** – Up to 12 months through **CareCredit**
4. **Payment Plan** - 50% paid at the time of service, then remaining balance is divided into no more than three monthly payments.
5. **Prepayment Courtesy** - 5% cash/check or 3% credit card courtesy on payments of $1,000 or more when paid while scheduling, prior to the appointment date.

Dental Insurance:

As a courtesy for patients with dental insurance, we are happy to submit insurance claims on your behalf to 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.

By signing below, you understand that you are responsible for all costs of treatment. In the event, your account should become more that 60 days late, your account will be charged one and one-half percent (1.5%) per month interest. Any account considered 90 days late may be sent to a collection agency. There will be a $250 service charge added to all accounts sent out to collections. In the event legal action is taken, you agree to be responsible for all attorney fees and court costs.

Missed Appointments:

When you schedule an appointment in our office, your appointment time is reserved exclusively for you. In an effort to keep your services rendered affordable, we reserve the right to charge patients who do not provide 48 hour advance notice or fail to show up to their scheduled appointment. This charge is not billable to insurance and must be paid prior to rescheduling any future appointments or requesting a transfer of records. We certainly understand there are unexpected situations that may arise, so please call our office as soon as possible. If you need to cancel an appointment on a Monday, please call our office by 10:00 am the Thursday before your appointment.

_____	_____	_____
Patient's Name Printed	Patient/Guardian's Signature	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

Shauna Gilmore, DDS

Authorization to Release Dental Information

Patient's Name _____

Patient's Address _____

_____

Patient's Phone _____

Release From: Dr. Name _____

Dr. Address _____

_____

Dr. Phone _____

I request and authorize _____ to release the information specified below to Shauna Gilmore, DDS, PC. Please send to Dr. Gilmore by email info@drsgilmore.com, fax 720-529-1376, or US 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. With 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

Print Save Reset Submit