EC Family & Cosmetic Dentistry
700 Broadway, Suite 1133
Denver, CO 80203
Phone: 303 - 863 - 1177
info@ecfamilydentist.com

Please take a few minutes to fill out this form as completely as you can.
If you have questions, we will be glad to help you.
We look forward to working with you in maintaining your oral health.

PATIENT INFORMATION

Last Name	First Name		M.I.	Nickname	
Mailing Address		City		State	Zip
Date of Birth	SSN	Gender		Marital Status	
Home Phone	Cell Phone	Work Phone		E-Mail	
Employer		Occupation			
Whom may we thank for referring you?					
Emergency Contact Name	Emergency Contact Phone Number		Relationship to Patient		

PRIMARY INSURANCE

Insurance Company	Subscriber ID Number	Group Number	Effective Date	
Insurance Company Address		City	State	Zip
Subscriber Name (Last, Middle, First)		Subscriber SSN	Subscriber Date of Birth	
Subscriber Mailing Address (If Different From Above)		City	State	Zip
Subscriber Home Phone	Subscriber Cell Phone	Subscriber Work Phone	Subscriber E-Mail	
Subscriber's Employer		Subscriber's Occupation		
Relationship to Patient	Name of Other Dependents on This Plan			

ADDITIONAL INSURANCE

Insurance Company	Subscriber ID Number	Group Number	Effective Date	
Insurance Company Address		City	State	Zip
Subscriber Name (Last, Middle, First)		Subscriber SSN	Subscriber Date of Birth	
Subscriber Mailing Address (If Different From Above)		City	State	Zip
Subscriber Home Phone	Subscriber Cell Phone	Subscriber Work Phone	Subscriber E-Mail	
Subscriber's Employer		Subscriber's Occupation		
Subscriber's Relationship to Patient	Name of Other Dependents on This Plan			

DENTAL HISTORY

What would you like us to do today?	Are you in any dental discomfort today?

Name of Former Dentist	Address/City/State/Zip	Phone Number

Date of last dental care?	Date of last dental X-Ray?	Is there anything you would like to improve about your smile? (Shade, Alignment, etc...):

Please check all that apply.

	Yes	No		Yes	No
Experiencing bad breath?	☐	☐	Any periodontal (gum) treatment?	☐	☐
Bleeding gums when you floss or brush?	☐	☐	Any orthodontic (braces) treatment?	☐	☐
Sensitivity to hot or cold?	☐	☐	Grinding or clenching teeth?	☐	☐
Loose teeth?	☐	☐	Clicking or popping jaw?	☐	☐
Sensitivity when biting?	☐	☐	Broken fillings?	☐	☐
Sores or growths in mouth?	☐	☐	Sensitivity to sweets?	☐	☐

MEDICAL HISTORY

Physician's Name	Address/City/State/Zip	Phone Number

Have you had any serious illness or operation? If YES please specify.	
Are you currently under physician's care? If YES what condition(s) is being treated.	

Do you need to pre-medicate and/or antibiotics before dental procedures? ☐ Yes ☐ No

Date of last physical exam:

WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No If YES, number of weeks:	Taking birth control pill or hormonal replacement? ☐ Yes ☐ No	Are you currently nursing? ☐ Yes ☐ No

Please list all the **medication** you are currently taking.	Please list all **allergies**, if any.

Please check all that apply or do not apply.

	Yes	No		Yes	No		Yes	No
HIV/AIDS	☐	☐	Diabetes, Type I or II	☐	☐	Pacemaker/Heart Surgery	☐	☐
Anaphylaxis	☐	☐	Emphysema	☐	☐	Radiation Treatment	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Epilepsy/Seizures	☐	☐
Angina	☐	☐	Headaches/Migraines	☐	☐	Fainting	☐	☐
Arteriosclerosis	☐	☐	Heart Murmur	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Arthritis, Rheumatism	☐	☐	Heart Problems	☐	☐	Shingles	☐	☐
Artificial Heart Valves	☐	☐	Hemophilia/Abnormal Bleeding	☐	☐	Shortness of Breath	☐	☐
Artificial Joints	☐	☐	Herpes/Cold Sores	☐	☐	Skin Rash	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Atopic (Allergy Prone)	☐	☐	High Blood Pressure	☐	☐	Surgical Implants	☐	☐
Back Problems	☐	☐	Low Blood Pressure	☐	☐	Swelling of Feet/Ankles	☐	☐
Blood Disease	☐	☐	Kidney Disease/Malfunction	☐	☐	Thyroid Disease/Malfunction	☐	☐
Cancer	☐	☐	Liver Disease	☐	☐	Nervous Problems	☐	☐
Chemotherapy	☐	☐	Material Allergies (Latex, Metals,			Cortisone Treatments	☐	☐
Chemical Dependency	☐	☐	Chemicals)	☐	☐	Tobacco/Vape Habit	☐	☐
Circulatory Problems/Fainting	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Cough, Persistent	☐	☐	Venereal Disease	☐	☐	Tuberculosis	☐	☐
Cough up Blood	☐	☐	Ulcers/Colitis	☐	☐	Jaw Pain	☐	☐
Psychiatric Care	☐	☐	If YES, please describe:					

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Ciula to help determine the appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Ciula

Signature of Patient or Guardian:_____ Date:_____

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 medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia)**. 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**. Holdings 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, infections, or bleeding**.
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, 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 regarding all dental procedures that are recommended to you.

HIPAA PRIVACY NOTICE (CONDENSED VERSION)

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THAT INFORMATION. A full version is posted in the office and on our website.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice

Care – We may discuss your care with providers within this office and other doctors you may be seeing. Payment – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service and your insurance company.

AUTHORIZATION NOT REQUIRED

The Practice may use and/or disclose your PHI, without a written Authorization from you in certain instances as only allowed by law. These instances are fully described in the full version of the Privacy Statement.

AUTHORIZATION

As a rule, we will NOT give out your PHI without you're authorization.

APPOINTMENT REMINDER

We may provide you with an appointment reminder in the form of a phone call, email or text message.

TREATMENT ALTERNATIVES/BENEFITS

The Practice may, from time to time, contact you about treatment alternatives it offers, or other health benefits or services that may be of interest to you through letters or e-mail.

YOUR RIGHTS

You have certain rights as required by law which are fully spelled out in the full version.

PRACTICE'S REQUIREMENTS

The dental office: EC Family & Cosmetic Dentistry

I have read and understand the statements on this page.

HIPAA Acknowledgment Signature:_____ Date:_____

FINANCIAL POLICY

Thank you for choosing our office for your dental needs. The following is our Financial Policy. Please read it carefully.

For your convenience we accept; Cash, Checks, VISA, MasterCard, Discover and Care Credit.

Please be aware that insurance is a contract between you and your insurance provider. Dr. Ciula is not a party to this contract. We plan our patient's treatment with an effort to provide the best, most complete care possible. This may or may not coincide with your insurance coverage. We will make every effort to work with insurance, but ultimately you, the patient, is responsible for all charges incurred.

As a courtesy our office will prepare and submit insurance claim forms when all of the insurance information is provided.

The patient is responsible for all charges left unpaid by their insurance company; including but not limited to annual deductibles and copays. Deductibles and copays are to be made at the time services are rendered.

AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize Dr. Ciula to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to my insurance, third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Ciula to release all information necessary to secure the payment of benefits. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account **REGARDLESS** of my insurance.

Late Charges: If I do not pay the entire new balance due within 25 days of the monthly billing date, a late charge of 1.5% (18% annually) on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signature of Patient or Guardian:_____ Date:_____