Chart #:________
FOR OFFICE USE ONLY

Patient Information

Patient Name:____ Date:__________
Last, First MI

Please circle one: Married, Single, Child, Other__________ Please circle one: Male/Female

Social Security #:__________________________ Birth Date:____________________

Phone (Home):____________(Work)____________ Ext_____Fax: ____________Email____________

Driver's License #________________Nickname____________Height:________Weight:________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ________________ ***Reason for this visit:*** ____________________

Have your ever had any of the following? Please check those that apply:

- ☐ 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:
- ☐ ________________
- ☐ ________________

- 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 change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ________________

Name of person or office referring you to our practice: ______________________________

Spouse or Responsible Party 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: ________________

Phone (Home): ____________ *(Work)*: ____________ Ext: ______ *Best time to call:* __________

Address: ____
Street Apartment #

____
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's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

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's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that I will be responsible for all collection charges and attorney fees if my account is turned over to a collection agency.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breech of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand I will be charged $46.00 for missed appointment or those not canceled within 24 hours.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and to submit my insurance with Signature on File.

I have read the above conditions of treatment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ____________
Signature of patient, parent or guardian

CAMERON AUGER, DDS, PC
18801 EAST HAMPDEN AVE., SUITE 178
AURORA, CO 80013-3585
PHONE: 303-680-3308
FAX: 303-680-3928

Billing and Collection Policies

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 additional fees not covered by the co-payment will be billed to patient. Any overpayments will be returned to patient promptly.

We bill your insurance company as a service to you. Our billing the insurance company does not guarantee that your insurance company will pay your bill. You are ultimately responsible for the cost of all services provided.

We will send out statements by the 1st of every month.

We do not add finance charges to statements over 30 days past due, but after 90 days the outstanding account will be sent to collections. Collection fees may be added to the outstanding account.

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

Any exceptions to the outlined policies must be approved by Dr. Auger prior to appointment. In cases of exceptions, specific agreements with exact time frames will be given. If agreement is not upheld, the case will be sent to collections. Additional collection fees may be added to accounts.

If payment is not made as agreed, patient shall be responsible for any reasonable attorney fees, costs of collection and court costs incurred in efforts to enforce this agreement.

DATE: ______________________ PLEASE PRINT

______________________________ ______________________________

Signature of patient or guardian | Last name First Middle

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 (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. 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 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 in regard to all dental procedures that are recommended to you.

Please note: We do not do 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 minor patient) Date.