Beth F. Kreider, DDS
700 Broadway, Suite 1133
Denver, CO 80203
(303)863-1177
info@drbethkreiderdds.com

We are pleased to welcome you to our practice. 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

Name _____ SSN# _____
Last First Middle

Address _____
City _____ State _____ Zip _____ Home Phone# _____
Sex M☐ F☐ Date of Birth _____ Single☐ Married☐ Widowed☐ Divorced☐ Cell Phone # _____
Patient Employed By _____ Occupation _____
Business Address _____ Business Phone # _____
E-mail Address _____
Whom may we thank for referring you? _____
Whom to notify in case of emergency? _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last First Middle

Relationship to Patient _____ Date of Birth _____ SSN# _____
Address(if different from patient) _____
City _____ State _____ Zip _____ Home Phone# _____
Person Responsible Employed By _____ Business Phone # _____
Insurance Company _____
Insurance Co. Address _____ City _____ State _____ Zip _____
Group # _____ Subscriber ID# _____ Insurance Phone # _____
Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? _____Yes _____No (If yes, please fill out following)

Subscribers Name _____
Last First Middle

Relationship to Patient _____ Date of Birth _____ SSN# _____
Address(if different from patient) _____
City _____ State _____ Zip _____ Home Phone# _____
Person Responsible Employed By _____ Business Phone # _____
Insurance Company _____
Insurance Co. Address _____ City _____ State _____ Zip _____
Group # _____ Subscriber ID# _____ Insurance Phone # _____
Name of other dependents under this plan _____

BETH F. KREIDER, DDS

DENTAL HISTORY

What would you like us to do today?_____Are you in any dental discomfort today?_____
Former Dentist_____Address_____Phone #_____
Date of last dental care_____Date of last dental x-rays _____
Please mark an (x) if you have had problems with any of the following:
_____Bad Breath _____Food Collection between Teeth _____Periodontal Treatment _____Sensitivity to Sweets
_____Bleeding Gums _____Grinding or Clenching Teeth _____Clicking or Popping Jaw _____Sensitivity when Biting
_____Sensitivity to Cold _____Sensitivity to Hot _____Loose Teeth or Broken Fillings _____Sores or Growths in Mouth

SLEEP HISTORY

Do you Snore? _____ Do you have High Blood Pressure? _____What is your Neck Size? _____ Do you Wake Refreshed _____
Has anyone reported that you Choke or Gasp for air while sleeping _____ Are you excessively tired during the day? _____

MEDICAL HISTORY

Physicians's Name _____ Phone # _____
Date of Last Visit _____ Have you had any serious illness or operations? _____Y _____N
If Yes, please describe _____
Are you currently under physician's care? _____Y_____N If yes, please describe _____
Have you ever had a blood transfusion? _____Y_____N If yes, approximate date _____
WOMEN: Are you pregnant? _____Y_____N Nursing _____Y_____N Taking Birth Control Pills _____Y_____N

Please mark an (x) if you have or have had any of the following:

_____AIDS/HIV+	_____Cough, Persistent	_____Hepatitis	_____Rheumatic/Scarlet Fever *
_____Anaphylaxis	_____Cough up Blood	_____High Blood Pressure	_____Shingles
_____Anemia	_____Diabetes	_____Jaw Pain	_____Shortness of Breath
_____Arthritis, Rheumatism	_____Epilepsy	_____Kidney Disease/ Malfunction	_____Skin Rash
_____Artificial Heart Valves*	_____Fainting	_____Liver Disease	_____Stroke
_____Artificial Joints*	_____Food Allergies	_____Material Allergies(Latex,	_____Surgical Implants*
_____Asthma	_____Glaucoma	metal, chemicals)	_____Swelling of Feet /Ankles
_____Atopic(Allergy Prone)	_____Headaches	_____Mitral Valve Prolapse*	_____Thyroid disease/Malfunction
_____Back Problems	_____Heart Murmur *	_____Nervous Problems	_____Tobacco Habit
_____Blood disease	_____Heart Problems*	_____Pacemaker/Heart Surgery	
_____Cancer	_____Psychiatric Care, Please Describe _____		_____Tonsillitis
_____Chemical Dependency	_____		_____Tuberculosis
_____Chemotherapy	_____Hemophilia/Abnormal Bleeding		_____Ulcers/Colitis
_____Circulatory Problems	_____Herpes	_____ Radiation Treatment	_____VenerealDisease
_____Cortisone Treatments			

* Antibiotic premedication may be required prior to your appointment.

Please list all medication you are currently taking.

_____
_____
_____

Please list allergies, if any.

_____
_____
_____

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. Kreider to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Kreider.

_____
Signature of Patient or Guardian Date

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

I have read and understand the statement on this page:

_____ _____

Patient's or Guardian's Signature Date

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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. Kreider 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. Kreider 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 pay-ors 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. Kreider 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.

X_____

Signature of Patient or Guardian Date