

**BROADMOOR DENTAL**

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH ____/____/____ MALE: [] FEMALE: [] SS# ____/____/____ TELEPHONE: _____

CELL PHONE: _____ WORK PHONE: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PARENT/GUARDIAN: _____ PARENT OR GUARDIAN SS# ____/____/____ WEIGHT: _____

EMERGENCY/OTHER CONTACT: _____ TELEPHONE: _____

Are you in pain? _____ Where (example: upper right tooth)? _____ How long? _____
 Has anything you have tried helped (example: pain pills)? _____ How long has it been since your last cleaning and examination? _____
 Do you have any specific concerns about your teeth or dental care? _____
 Do you or have you pre-medicated for dental visits, meaning have you been advised to take antibiotics prior to having dental care? _____ "Yes" or "No".
 If yes, why? _____ Are you pregnant? If so enter due date: ____/____/____ Are You Nursing? Yes/No

Health History Of The Following	Indicate Yes or No		Health History Of The Following	Indicate Yes or No		List All Medications You Are Presently Taking:	What Is The Medication Being Taken For?	How Often Are You Taking The Medication?
Anemia	Y	N	Heart Attack	Y	N			
Arthritis	Y	N	Hemophilia	Y	N			
Artificial Heart valves	Y	N	Hepatitis	Y	N			
Artificial Joints	Y	N	High Blood Pressure	Y	N			
Asthma	Y	N	HIV/AIDS	Y	N	DO YOU HAVE ALLERGIES TO MEDICATIONS OR A DVERSE REACTIONS TO ANY DENTAL/MEDICAL TREATMENTS?		
Back Problems	Y	N	Jaw pain	Y	N			
Blood Disease	Y	N	Kidney Disease	Y	N			
Cancer	Y	N	Mitral Valve Prolapse	Y	N	DESCRIBE ANY OTHER MEDICAL ISSUES OR SURGERIES:		
Chemical Dependency	Y	N	Neurologic Problems	Y	N			
Chemotherapy	Y	N	Pacemaker	Y	N			
Circulatory Problems	Y	N	Psychiatric Care	Y	N	PLEASE PRESENT YOUR INSURANCE CARD & ANY CHANGES IN YOUR INSURANCE INFORMATION SO THAT WE MAY ASSIST YOU IN CLAIMS PROCESSING		
Cortisone Treatments	Y	N	Radiation Therapy	Y	N			
Persistent Cough	Y	N	Rheumatic Fever	Y	N	Primary Insurance	Subscriber Name	Ins. Plan ID / Group No.
Diabetes	Y	N	Scarlet fever	Y	N			
Epilepsy	Y	N	Shortness of Breath	Y	N	Subscriber SSN	Subscriber Date of Birth	Relation to patient
Fainting	Y	N	Stroke	Y	N			
Glaucoma	Y	N	Swollen Ankles	Y	N	Secondary Insurance	Subscriber Name	Ins. Plan ID / Group No.
Headaches	Y	N	Thyroid Problems	Y	N			
Heart Mummur	Y	N	Tobacco Habit	Y	N	Subscriber SSN	Subscriber Date of Birth	Relation to patient
Heart Problems	Y	N	Tuberculosis	Y	N			

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, or medications, or medical treatments I will inform the doctors at the next appointment without fail.

Printed Name: _____ Date: _____ Parent/Guardian of: _____

Signature: _____

DOCTOR SIGNATURE: _____

Broadmoor Dental Office Policy

Nicolas R. Pruett, D.D.S.
Christopher Mazzola, D.D.S.
Christina Mazzola, D.D.S

Signature: I certify that I, _____, (or my dependent) have dental insurance coverage and assign directly to Broadmoor Dental all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Patients without dental insurance coverage understand that they are responsible for 100% of the fees on or before the day of treatment.

Payments: Pre-payment is required for all prescribed/accepted dental treatment. Collecting in advance allows our office to reserve your time with the doctor. When you prepay for treatment you are agreeing to take care of your dental needs. Money that you prepay/pay for needed dental treatment will not be refunded. However, if you are refusing treatment and insist on a refund, you will be responsible for all charges incurred and may be assessed a cancellation fee. We have several payment methods we offer to our patients to assist them in taking care of their dental needs. If you use one of our finance companies and decide to change the terms of your account you will be responsible for all charges incurred. A \$25.00 fee will be applied for any returned checks. A photo id is now required for all non-cash payments.

Billing Policy: As a courtesy, we will bill your insurance company for services rendered. Once payment is received from the insurance company, you will receive ONE patient statement for the balance due. It is expected that your payment will be made in 10 (ten) days. If your payment is not received, it will be considered past due and may be sent to collections. We reserve the right to impose a service charge of 2 % per month (18% per annum) on the unpaid balance on all accounts exceeding 30 days, unless previously written financial arrangements have been made. If an account is turned over to a collection agency and/or attorney for collection, the account holder will be responsible for all attorney and/or collection fees. Any balance that is ninety days (90) past due is subject to being sent for collection.

Unpaid Insurance Benefits: I understand that all dental services furnished, whether the patient has insurance or not, are charged directly to the patient and that he or she is personally responsible for payment of all dental services. If an insurance company has not paid a claim after sixty days (60) of it being submitted, the office will require that the patient pay the account in full. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. A photo id is now required with all insurance cards. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Treatment Estimates: The office routinely provides our patients with an estimate of cost for prescribed treatment. Since your insurance determines the benefits payable for services the office cannot be held responsible for 100% accuracy on any estimate for treatment.

Alternate Benefits: I understand that most insurance companies downgrade coverage on non-metal restorations and I agree to the adjusted fees for upgraded materials.

Condition of Treatment: As a condition of treatment by this office, financial arrangements must be made in advance, and financial responsibility (whether insurance remittance or patient portion) on the part of each patient is determined before treatment. All emergency dental services, or any dental service performed without financial arrangements, must be paid in full at the time services are performed.

Missed or Broken Appointments: Rescheduling an appointment may be done up to 48 hours prior to your scheduled appointment without expense. You will be assessed a \$50.00 fee for the second missed appointment, and a \$100.00 for the third missed appointment, after which the practice reserves the right to dismiss patients due to repeated rescheduling or missed appointments.

Broadmoor Dental reserves the right to update this Office Policy at any time without notification
My signature verifies that I have read, understood, and accepted the policies described above, and further grant you or your assignee permission to telephone me at home or at my work to discuss matters related to this form.

Signature: _____ **Date:** _____



Broadmoor Dental

Oral Cancer Screening Consent Form

1930 S. Nevada ~ Colorado Springs ~ Colorado ~ 80905 ~ (719) 576.5566 ~ info@broadmoordental.com

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Studies also suggest that human papillomavirus (HPV) plays a roll in more than 20% of oral cancers causes. Oral cancer risk by patient profile as follows:

Increased Risk:	Patients ages 18 – 39 Sexually active patients
High Risk:	Patients 40 and older Tobacco users: ages 18-39, any type within 10 years
Highest Risk:	Patients 40 and older w/ lifestyle risk factors (tobacco and/or alcohol use) Previous history of oral cancer

Broadmoor Dental has incorporated VELscope into our oral screening standard of care. VELscope, in conjunction with a standard oral cancer examination, significantly improves the ability to identify suspicious areas at their earliest stages. VELscope powered by Sapphire, along with the doctor's visual examination, is similar to proven early detection procedures for other cancers such as mammography, and gives the best chance to find any abnormalities at the earliest possible stage. As with all cancer early detection can minimize or eliminate potentially disfiguring effects and possibly save your life.

The VELscope powered by Sapphire examination will be offered to you annually. This enhanced examination is recognized by the American Dental Association, however it is not recognized by most insurance companies. **The fee for this enhanced examination is \$25.00 and is due on the date of service.**

- Yes. Along with my standard oral cancer screening, I would prefer to have the VELscope enhanced examination at this time.
- No. I would prefer not to have the VELscope enhanced examination at this time and prefer the standard oral cancer screening alone.

Print Name _____ Signature _____ Date _____