JOHN S. WALKER, D.M.D
Specialist in Orthodontics
350 Broadway Suite 120
Boulder, CO 80305
Phone 303-494-3535 Fax 303-494-5095

Welcome to Our Office

Please, whom may we thank for referring you to our office?_____

Today's Date: _____ Nickname: _____

PATIENT LEGAL NAME:_____ Age:_____ Sex_____: Marital Status:_____

Address:_____ Home Phone: _____

City,_____ State,_____ Zip:_____ Cell Phone: _____

Patient E-mail: _____ Birthdate: _____

Personal Dentist:_____ City: _____ Occupation:_____

RESPONSIBLE PARTY 1:

Name of person responsible for this account:_____ Relationship to Patient: _____

Address: _____ Home Phone: _____

City,_____ State,_____ Zip_____ Cell Phone: _____

E-mail: _____Birth Date: _____ Social Security Number:_____

RESPONSIBLE PARTY 2:

Name of person responsible for this account:_____ Relationship to Patient: _____

Address: _____ Home Phone: _____

City,_____ State,_____ Zip_____ Cell Phone: _____

E-mail: _____Birth Date: _____Social Security Number:_____

DENTAL INSURANCE INFORMATION:

Name of insured:_____Relationship to Patient:_____

Insurance Company:_____Policy ID#: _____Group#_____

Ins. CO. Address: _____ Birthdate: _____ SSN :_____

City: _____ St._____ Zip: _____ Employer:_____

DO YOU HAVE ADDITONAL INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured:_____Relationship to Patient:_____

Insurance Company:_____Policy ID#: _____Group#_____

Ins. CO. Address: _____ Birthdate: _____SSN:_____

City: _____ St._____ Zip: _____ Employer:_____

HEALTH HISTORY

Name of family physician:_____ Address:_____

How is your general health? __ Excellent ___ Good ___ Fair ____Poor
Do you have, or have you ever had, any of the following? (Circle all that apply)

Heart Disease	**Diabetes**	**Tumor History**	**Liver or Kidney Disease**
High Blood Pressure	**Stroke**	**Venereal Disease**	**Tuberculosis**
Blood Disorder, Anemia	**Epilepsy**	**Sinus Trouble**	**Asthma, Emphysema**
Rheumatic Fever	**Fainting**	**Ulcers**	**Allergies**
Heart Murmur	**Psychiatric Treatment**	**Hepatitis**	**AIDS**
Thyroid Disease	**Arthritis**	**Radiation Treatment**	**HIV**

Have you ever been hospitalized and/or had surgery within the last five years (if YES, please explain) YES NO-

_____

_____

Are you under the care of a physician now? Explain: _____ YES NO
Are you taking medication, drugs or pills? (if YES, list): _____YES NO
Are you allergic or sensitive to penicillin or ANY other drugs or medicine? Explain: _____ YES NO
Do you have disease, condition or problem not listed above? (if YES, list):_____ YES NO
Do you smoke? YES NO
WOMEN: Are you pregnant? YES NO Delivery Date:_____
Remarks: _____

DENTAL HISTORY

When was your last dental visit?_____
What was done then? _____
Are you now in discomfort, requiring our immediate attention? _____ YES NO
Have you had regular dental checkups? _____ YES NO
Do you gums bleed when brushing or flossing? _____ YES NO
Have you been told you have a gum problem? _____ YES NO
Have there been any complications during previous dental treatment? _____ YES NO
Do you have chronic headaches, neck or shoulder pain or all? _____ YES NO
Do you clench or grind your teeth during wake or sleep? _____ YES NO
Do you jaws feel tired or sore when you're awake? _____ YES NO
Do your jaw joints grind, pop, click or lock open when your mouth is wide open? _____ YES NO
In your own words, what are the problems you would like Dr. Walker to help you with? _____

_____

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT:
I authorize Dr. Walker to examine the above named patient and I HAVE READ, AND UNDERSTAND, AND HAVE ANSWERED THE ABOVE QUESTIONS.

Date:_____ _____
PATIENT, PARENT, OR LEGAL GUARDIAN PLEASE SIGN HERE

INITIAL DIAGNOSIS

CL I II III Subdivision Overbite Overjet Midline_____

Dentition_____ Approx. Fee _____

Disposition Records Recall_____ Months Approx. Time_____

_____

_____

_____

_____

_____

_____

_____

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Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I,_____, have received a copy of this office's Notice of Privacy Practices.

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:

D Individual refused to sign

D Communications barriers prohibited obtaining the acknowledgement

D An emergency situation prevented us from obtaining acknowledgement

D Other (Please Specify)

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Our policy is to bill the patient's insurance company for service rendered. However, insurance coverage is another form of payment but ultimately it is your responsibility to pay for all services rendered. If you do not have insurance, payment is due at the time services are rendered. We will collect any known or estimated co-payments, co- insurance or deductibles at the time of service. Additionally, the responsible party will be billed for services rendered in full, should the insurance company deny coverage due to non-covered benefits, lack of referral, lack of proper reporting of incident/accident or lack of individual coverage, where applicable.

Any account balance(s) that are not paid by 120 days from the date of service or monthly charge may be forwarded to a collection agency. If deemed necessary, Boulder Valley Orthodontics reserves the right to forward the account balance(s) to a collection agency prior to 120 days from the date of service or monthly payment due. Any and all phone numbers provided to our office be it residential, employment or wireless, are authorized methods of communication by our office or by a collection agency in regards to any outstanding collection balances. Should collections be necessary, any payment made to the collection agency via an electronic payment (such as a check over the phone or credit card) will incur a convenience fee. A convenience fee is a fee incidental to your payment obligation. Should litigation be necessary to collect an amount owed, the responsible party agrees to pay all costs of collection including, but not limited to, collection fees, attorney fees, interest at the rate of 18% and court costs.

Patient _____

Responsible Party Signature: _____

Date _____