COLORADO
SMILE DESIGN

Philip E. Wimpee, DDS, PC

Welcome to The office of Dr. Philip Wimpee

We are complimented that you have selected us to provide dental care for you and your family.
Please review this print-out, and sign the Consent For Treatment on Page 2.

PATIENT INFORMATION

E-mail: Date Submitted:

Patient Name:

Address:

City: State: Zip:

How long at this address:

Home Phone: Cell Phone:

Birthdate: Social Security Number:

If patient is a minor, give parent's or guardian's name:

Employer: Work Phone:

Occupation: Time here:

Spouse Name: Spouse Birthdate:

Spouse Social Security Number: Spouse Employer:

Spouse Occupation: Time here:

How did you learn about our office:

If you were referred by someone, whom may we thank?

RESPONSIBLE PARTY / BILLING INFORMATION

Responsible Party Name:

Address:

City: State: Zip:

How long at this address:

Home Phone: Work Phone:

Social Security Number: Birthdate:

Relationship to patient:

Employer: Occupation: Time here:

Spouse Name: Spouse Birthdate:

Spouse Social Security Number: Spouse Employer:

Spouse Occupation: Time here:

INSURANCE INFORMATION

Insured's Name: Insured's Birthdate:

SSN / ID#: Insurance Company:

Group Number: Insurance Phone:

Address:

City: State: Zip:

Do you have dual coverage? ☐ Yes ☐ No

Insured's Name: Insured's Birthdate:

SSN / ID#: Insurance Company:

Group Number: Insurance Phone:

Address:

City: State: Zip:

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T 303-979-2900

Patient Name: _____ **Date Submitted:** _____

CONSENT FOR TREATMENT

I hereby authorize Dr. Philip Wimpee to administer any treatment and to perform such x-rays, anesthetics, and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

I authorize release of any information relating to this claim. I realize that I am ultimately responsible for all costs of dental treatment.

I hereby authorize my insurance benefits to be paid directly to Dr. Philip Wimpee.

Date:_____ Signature (patient or parent for minor)_____

After initial x-rays and examination, we will give you an estimate of fees to cover your treatment. At that time financial arrangements will be made before treatment is rendered.

Preferred method of payment: _____Cash _____Check _____Bankcard

MEDICAL HISTORY

To the best of my knowledge, all of the following answers are correct. If my health or medications change, I will inform Dr. Philip Wimpee at my next appointment.

Date:_____ Signature (patient or parent for minor)_____

Who is your primary care physician? _____ **Physician's Phone:** _____

How would you describe your overall health? _____ **When was your last physical?** _____

Have you been hospitalized under a physician's care in the last two years? ☐ **Yes** ☐ **No**

If so, why? _____

Please list all medications/drugs you are taking: _____

Have you ever had an adverse reaction or allergies to any medication or substance? (Please check if allergic.)

- ☐ **Aspirin**
- ☐ **Codeine**
- ☐ **Erythromycin**
- ☐ **Iodine**
- ☐ **Latex**
- ☐ **Nitrous Oxide**
- ☐ **Novocaine**
- ☐ **Penicillin**
- ☐ **Sulfa Drugs**
- ☐ **Tetracycline**
- ☐ **Valium**
- ☐ **Xylocaine**

Others: _____

Have you ever had any of the following? (Please check all that apply)

- ☐ **Allergies**
- ☐ **Arthritis or Gout**
- ☐ **Artificial Joint**
- ☐ **Asthma**
- ☐ **Bleeding Problem or Anemia**
- ☐ **Blood Transfusion**
- ☐ **Blood disease**
- ☐ **Bruise Easily**
- ☐ **Cancer**
- ☐ **Cold Sores**
- ☐ **Congenital Heart Problems**
- ☐ **Currently Pregnant**
- ☐ **Diabetes**
- ☐ **Dizziness or Fainting**
- ☐ **Drug/Alcohol Addiction**
- ☐ **Eating Disorder**
- ☐ **Emphysema**
- ☐ **Epilepsy or Seizures**
- ☐ **Fever Blisters**
- ☐ **Frequent Thirst**
- ☐ **Frequent Urination**
- ☐ **Glaucoma**
- ☐ **HIV-AIDS-ARC**
- ☐ **Heart Attack or Stroke**
- ☐ **Heart Murmur**
- ☐ **Heart Trouble**
- ☐ **Heart Valve or Pacemaker**
- ☐ **Hepatitis (A)**
- ☐ **Hepatitis (B)**
- ☐ **Hepatitis (C)**
- ☐ **Herpes**
- ☐ **High Blood Pressure**
- ☐ **Hypoglycemia**
- ☐ **Jaw Joint Pain**
- ☐ **Kidney or Liver Disease**
- ☐ **Low Blood Pressure**
- ☐ **Lung Disease**
- ☐ **Psychiatric Care**
- ☐ **Radiation/Chemotherapy**
- ☐ **Rheumatic Fever**
- ☐ **Sinus Problems**
- ☐ **Thyroid Problems**
- ☐ **Tuberculosis**
- ☐ **Tumor or Growth**
- ☐ **Ulcers or G.I. Problems**
- ☐ **Use Tobacco**
- ☐ **X-ray/Chemotherapy**

Do you have any condition or problem not listed which we should know about? Please explain: _____

Have you ever been given antibiotics before dental treatment? ☐ **Yes** ☐ **No**

Have you recently consumed alcohol? ☐ **Yes** ☐ **No**

Have you recently used recreational drugs? ☐ **Yes** ☐ **No**

Recreational use combined with local anesthesia may cause a life-threatening emergency.

Patient Name: Date Submitted:

DENTAL HISTORY

What are your present dental concerns?

When was your last dental visit? When were your last dental x-rays?

When was your last cleaning?

Have you avoided regular dental care? ☐ Yes ☐ No Why?

Do you feel you have active decay? ☐ Yes ☐ No Do you experience frequent bad breath? ☐ Yes ☐ No

Do you feel you have gum disease? ☐ Yes ☐ No Have you ever had gum treatments? ☐ Yes ☐ No

How often do you brush? Floss?

Use other aids?

Are you happy with the appearance of your teeth? ☐ Yes ☐ No

Would you like your teeth to be whiter? ☐ Yes ☐ No

What are your dental expectations?

Name of previous dentist: City: State:

How would you rate your previous dental experience?

NEAREST RELATIVE

Name of nearest relative not living with you? Phone:

Address:

City: State: Zip: