Dr. Guy F. Grabiak, DMD, FAGD
5920 S Estes ST #200 Littleton, Co 80123
303-988-6118 Fax 720-573-1405 Grabiakfrontdesk@gmail.com

Patient Information:

Today's Date: ______________

Name: ____ **Preferred Name:** ___________________

Date of Birth: ____/____/____ **Age:** ________ **SS#**__________________ **Driver License#**______________

Home Address: ____ **City**____________________ **Zip**__________

Home Phone: (_____) ______-_________ **Work Phone:** (_____) ______-______

Cell Phone: (______) ______-_________ **Email:** ____

Employer___________________________________ **Address**___________________________________

Occupation___________________ **Spouse's Name**__________________ **Phone**______________

Parent or Guardian if under 18 Years of age____

Emergency Contact _________________________________ **Relationship**_________________ **Phone**____________________

How Did You Hear About Us? ______________________________

Insurance Information

Primary Dental Insurance

Insured's
Name____
Birth Date______________ SS#_____________________
Employer __________________________________
Policy #_____________________
Insurance Company
Name__________________________________
Phone #________________________
Insurance Company
Address____

Secondary Dental Insurance

Insured's
Name____
Birth Date______________ SS#_____________________
Employer __________________________________
Policy #_____________________
Insurance Company
Name__________________________________
Phone #________________________
Insurance Company
Address____

THE INFORMATION I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I MUST INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS Consent

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all form of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate credit reports may be obtained.

Patient Signature (Parent or Guardian): ______________________________**Date:** ______________

Witness: _________________________ **Date:** _______________

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Medical History

Are you Under a Physician's Care now? Yes/No Family Physician __________________Phone Number___________

Do you use: Cigars/Cigarettes: Yes/No Pipe: Yes/No Chewing Tobacco: Yes/No Marijuana: Yes/No
Women: Are you Pregnant? Yes No Nursing? Yes No Oral Contraceptives? Yes No

Have you ever been hospitalized or had a major operation? Yes No When: ___________________

Have you ever had a serious head or neck Injury? Yes No When: ___________________
Are you taking any medications, pills, or drugs, marijuana? ____

____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No
Please note any & all allergies: ____

Aids/HIV Positive	Yes	No	Excessive Bleeding	Yes	No	Low Blood Pressure	Yes	No
Alzheimer's Disease	Yes	No	Excessive Thirst	Yes	No	Lung Disease	Yes	No
Anaphylaxis	Yes	No	Fainting Spells/Dizzy	Yes	No	Mitral Valve Prolapse	Yes	No
Anemia	Yes	No	Frequent Cough	Yes	No	Osteoporosis	Yes	No
Angina	Yes	No	Frequent Diarrhea	Yes	No	Pain in Jaw Joints	Yes	No
Arthritis/Gout	Yes	No	Frequent Headaches	Yes	No	Parathyroid Disease	Yes	No
Artificial Heart Valve	Yes	No	Genital Herpes	Yes	No	Psychiatric Care	Yes	No
Artificial Joint	Yes	No	Glaucoma	Yes	No	Radiation Treatments	Yes	No
Asthma	Yes	No	Hay Fever	Yes	No	Recent Weight Loss	Yes	No
Blood Disease	Yes	No	Heart Attack/Failure	Yes	No	Renal Dialysis	Yes	No
Blood Transfusion	Yes	No	Heart Murmur	Yes	No	Rheumatic Fever	Yes	No
Breathing Problems	Yes	No	Heart Pacemaker	Yes	No	Scarlet Fever	Yes	No
Bruise Easily	Yes	No	Heart Trouble/Disease	Yes	No	Shingles	Yes	No
Cancer	Yes	No	Hemophilia	Yes	No	Sickle Cell Disease	Yes	No
Chemotherapy	Yes	No	Hepatitis A	Yes	No	Sinus Trouble	Yes	No
Chest Pain	Yes	No	Hepatitis B or C	Yes	No	Spina Bifida	Yes	No
Cold Sores/Fever Blisters	Yes	No	Herpes	Yes	No	Stomach/Intestinal Disease	Yes	No
Congenital Heart Disorder	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Convulsions	Yes	No	High Cholesterol	Yes	No	Swelling of limbs	Yes	No
Cortisone Medicine	Yes	No	Hives or Rash	Yes	No	Thyroid Disease	Yes	No
Diabetes	Yes	No	Hypoglycemia	Yes	No	Tonsillitis	Yes	No
Drug Addiction	Yes	No	Irregular Heartbeat	Yes	No	Tumors or Growths	Yes	No
Easily Winded	Yes	No	Kidney Problems	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Leukemia	Yes	No	Venereal Disease	Yes	No
Epilepsy or Seizures	Yes	No	Liver Disease	Yes	No	Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed about? ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian ____ Date____________

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Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender: Male ◯ Female ◯	Neck Size +2 Male ≥16.5 +2 Female≥15.0
Height	Feet	Inches	**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

Co-morbidities +1 for each Yes response

Condition			Condition		
High blood pressure	Yes ◯	No ◯	Stroke	Yes ◯	No ◯
Heart disease	Yes ◯	No ◯	Depression	Yes ◯	No ◯
Diabetes	Yes ◯	No ◯	Sleep apnea	Yes ◯	No ◯

Score

Do not assign any points for these eight responses

Condition			Condition		
Lung disease	Yes ◯	No ◯	Nasal oxygen use	Yes ◯	No ◯
Insomnia	Yes ◯	No ◯	Restless leg syndrome	Yes ◯	No ◯
Narcolepsy	Yes ◯	No ◯	Morning Headaches	Yes ◯	No ◯
Sleeping Medication	Yes ◯	No ◯	Pain Medication e.g., vicodin, oxycontin	Yes ◯	No ◯

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze 1 = slight chance of dozing
2 = moderate chance of dozing 3 = high chance of dozing

Situation	0	1	2	3
Sitting and reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting, inactive, in a public place (theater, meeting, etc)	◯	◯	◯	◯
As a passenger in a car for an hour without a break	◯	◯	◯	◯
Lying down to rest in the afternoon when circumstances permit	◯	◯	◯	◯
Sitting and talking to someone	◯	◯	◯	◯
Sitting quietly after lunch without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Assign points for each of the first three responses

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?

Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you wake up choking or gasping?

Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯ Almost always ◯

Signature	Area Code	Phone Number	**Total all 6 boxes from above** If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	**Point Total**

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INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMATION: ____Slight ____Moderate ____Severe
SOFT PLAQUE BUILDUP: ____Slight ____Moderate ____Severe
HARD CALCULUS BUILDUP: ____Slight ____Moderate ____Severe
STAINS: ____Slight ____Moderate ____Severe
HOME CARE EFFECTIVENESS: ____Good ____Fair ____Poor
PERIODONTAL CONDITION: ____Good ____Fair ____Poor
PERIODONTAL DIAGNOSIS: ____ Normal Gingivitis____
PERIODONTIITIS: ____Early ____Moderate ___Advanced
MUCOGINGIVAL DEFFECTS #S:______________________________

CLINICAL DATA:

OCCLUSION:_____CLASS I _____CLASS II ____CLASSIII _____CROSSBITE
T.M.J. EXAM:_____NORMAL _____POPPING _____DEVIATION
_____TOOTH WEAR ____PAIN

INITIAL SOFT TISSUE EXAM

____LIPS _____FLOOR OF MOUTH _____PALATE _____TONGUE
_____NECK & NODES

PATIENT'S TREATMENT DECISIONS:

_____ DOCUMENTS OF DENTAL RECORD COMPLETED
_____ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)
_____ PATIENT WANTS NO TX. OR PARTIAL TX INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

INTIAL X-RAY FINDINGS:

X-RAYS TAKEN:___FM-PAS ____BWX____PANO.____OTHER________

____NO BONE LOSS
____ SLIGHT BONE LOSS (04600)
____ MODERATE BONE (04700)
____ MAJOR BONE LOSS (04800)
____ BEGINNING FURCATION (04700)
____ ADVANCED FURCATION (04800)

QUADRANTS

UR	UL	LR	LL

OTHER:____

SHADE

Teeth	UPPER	LOWER
CENTS		
LATS		
CUSP		
POSTS		

PERIODONTAL SCREENING & RECORDING

SEXTANT SCORE ------------------ DATE

EXISTING PROSTHESIS:

MAX:__________ Date Placed:_______________ Condition:___________
MAND:__________ Date Placed:__________ Condition:_____________

REFERRALS:

PERIO:__________ ORTHO:______________ ENDO:________________
ORAL SURG:______________MD:____________ OTHER:_______________

NOTES

____
____
____
____
____

CONSENT

The undersigned hereby authorizes the Doctor to take, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient Signature (parent of child)____ Date:______________

Dentist Signature__________________________ Date:______________

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FINANCIAL OPTIONS

• CASH OR CHECK

Receive a 5% bookkeeping courtesy by paying in full before the time of service. For treatment requiring more than one appointment, the entire treatment plan must be paid in advance in order to receive this 5% courtesy.

• CREDIT/DEBIT

Receive rewards, miles or cash back from your credit card company by paying in full at the time of service. We accept all major credit cards including MasterCard, Visa, Discover, and American Express. Many of our clients prefer to pay with their credit cards as it allows them to maximize their existing rewards program.

• DENTAL INSURANCE BENEFITS

Receive a bookkeeping courtesy when you pay in full at the time of service and allow your insurance company to process the claim and send the insurance benefit check directly to you. To help you maximize your benefits, we will complete and submit your insurance claim electronically for you. Once your insurance carrier has processed the claim, you will be reimbursed directly by them for any eligible benefits.

****NOTE: If you elect to assign your insurance benefits to our office, you must pay your estimated patient portion for your visit and leave a signed and valid credit card authorization form on file with us (complete the back of this form) which will be used to pay any remaining balance in the event your insurance company doesn't pay the expected, or estimated amount.**

• MONTHLY PAYMENTS

If you prefer to pay a little each month toward your dental care, we've made special arrangements with several, reputable third-party healthcare finance companies. This will allow you to complete your treatment and still be able to budget for affordable, monthly payments over time- many times with interest-free options and terms. One of our team members will be happy to discuss this payment option and current financing specials with you.

****NOTE: an administrative fee of 5% will be added to all financed treatment plans. (see terms and conditions of financing application).**

• TREATMENT DEPOSITS

A 10% deposit is required for all Doctor Visits, as well as any hygiene appointments during evening high demand appointment times. This deposit becomes non-refundable with less than 48 hours' notice of cancellation, missed or broken appointments, but may be transferred one time in the event of a last minute notification of a change in your schedule.

I understand my financial options and agree to one of the above arrangements. I understand any financial arrangement made to pay for my treatment outside of one of the options listed here will be discussed and decided on a case-by-case basis with management approval only and a valid credit card authorization form on file.

FINANCE CHARGE(S): If I do not pay the entire new balance of my account within 25 days of the billing date, a monthly finance charge will be assessed to my account for each current monthly billing period. The finance charge is currently a periodic rate of 1.5% per month, which is an APR of 18% applied to the last month's balance.

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CREDIT CARD AUTHORIZATION ON FILE: I understand and agree that my credit card may be charged for any patient portion or account balance that is $100.00 or less and my responsibility after insurance benefit, and/or for any past due balance that remains unpaid by either me or my insurance carrier after 60 days.

In the case of default of payment, I promise to pay all accrued finance charges, interest, and administrative fees on the balance due, together with any collection costs and attorney's fees incurred in order to collect on this account.

SIGNATURE: ____

DATE: ______________________

AUTHORIZATION FOR CREDIT CARD PAYMENTS

(CREDIT CARD ON FILE)

I, , understand that I have chosen to assign my dental benefits to Denver Dentistry and claim form(s) will be sent to my insurance company for treatment provided and/or I am entering into a financial arrangement with the office to pay for my dental treatment.

I further realize that I am ultimately responsible for the cost of treatment regardless of my insurance company's willingness to pay a benefit. I hereby authorize Denver Dentistry to keep my signature on file and to charge my credit card account for any and all treatment fees not paid by my insurance carrier or myself within 60 days or in agreement with the terms/dates of my financial arrangement.

****NOTE: We will make every effort possible to notify you in advance of your authorized card being charged for an amount greater than $100.00.**

____ ________________________________

Cardholder's Address 1 **Cardholder's Phone Number**

q MasterCard q Visa q AMEX q Discover

____

Credit Card Account #

_____/_____ __________

Exp Date CVV2

____ ______________________________

Cardholder's Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse To Sign This Acknowledgment****

If the patient is under the age of 18, a parent or legal guardian must sign.

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

Signature of Patient or Parent/Legal Guardian: ____

Date: ____________________________

For Patients Who Need To Pre-Medicate Only:

I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whoever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

Printed Name: ____

Signature of Patient or Parent/Legal Guardian: ____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice or Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communications barriers prohibited obtaining the acknowledgement ○ An emergency situation prevented us from obtaining acknowledgement ○ Patient reviewed Privacy Practices but elected not to take a copy home ○ Other (Please Specify)**

Employee Signature: ____ Date: _________________________