Kenneth L. Andow
DDS • PC

A lifetime of healthy smiles for your entire family

New Patient Information

Name: _____ Date: _____

What name would you like to be called: _____ Date of Birth: _____

Home Phone: _____ Social Security No: _____ Marital Status: ○S ○M ○D ○W

Cell Phone: _____

E-mail: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

Work Phone: _____ Occupation: _____

School Name (if full time student): _____ Grade: _____

Names of brothers and sisters (if child): _____

Dental Insurance Company: _____ Group#: _____

Whom may we thank for referring you to our office? _____

Family Information - Spouse (or Parent)

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Social Security No: _____ Date of Birth: _____

Employer: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

Work Phone: _____

Dental Insurance Company: _____ Group#: _____

Emergency Information - Person to contact in case of emergency (outside of immediate family)

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____

Account Information - Responsible party for patient

Name: _____

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Medical History

Name: _____ Date: _____

Medical Doctor's Name: _____ Phone: _____

Date of last examination: _____

Have you been under the care of a medical doctor during the past two months? YES ◯ NO ◯

If yes, why? _____

Have you ever been hospitalized for any serious illness or operation? YES ◯ NO ◯

If yes, please list: _____

Are you currently taking any medications, drugs or pills on a regular basis? YES ◯ NO ◯

If yes, please list: _____

Are you allergic to or have you ever reacted adversely to any medications? YES ◯ NO ◯

If yes, please list: _____

Indicate which of the following you have had or have at present. Mark either "YES" or "NO" next to each item.

Heart Failure	YES ◯ NO ◯	Anemia	YES ◯ NO ◯	Sinus Trouble	YES ◯ NO ◯	Arthritis/Gout	YES ◯ NO ◯	Artificial Heart Valve	YES ◯ NO ◯	Nervousness	YES ◯ NO ◯
Artificial Joints	YES ◯ NO ◯	Shortness of Breath	YES ◯ NO ◯	Liver Disease	YES ◯ NO ◯	Cancer	YES ◯ NO ◯	Cortisone Medicine	YES ◯ NO ◯	Heart Surgery	YES ◯ NO ◯
Chronic Cough	YES ◯ NO ◯	Diabetes	YES ◯ NO ◯	High Blood Pressure	YES ◯ NO ◯	Alzheimer's Disease	YES ◯ NO ◯	Hepatitis B (serum)	YES ◯ NO ◯	Stroke	YES ◯ NO ◯
Blood Transfusion	YES ◯ NO ◯	Hay Fever	YES ◯ NO ◯	Cosmetic Surgery	YES ◯ NO ◯	Arteriosclerosis	YES ◯ NO ◯	Parathyroid Disease	YES ◯ NO ◯	HIV Positive	YES ◯ NO ◯
Angina Pectoris	YES ◯ NO ◯	Sickle Cell Disease	YES ◯ NO ◯	Radiation Therapy	YES ◯ NO ◯	Lung Disease	YES ◯ NO ◯	Chest Pain	YES ◯ NO ◯	Psychiatric Treatment	YES ◯ NO ◯
Kidney Trouble	YES ◯ NO ◯	Heart Disease	YES ◯ NO ◯	Yellow Jaundice	YES ◯ NO ◯	Anti-Cancer Drugs	YES ◯ NO ◯	Drug Addiction	YES ◯ NO ◯	Valvular Dysfunction	YES ◯ NO ◯
Tuberculosis (TB)	YES ◯ NO ◯	Thyroid Problems	YES ◯ NO ◯	Low Blood Pressure	YES ◯ NO ◯	Hypoglycemia	YES ◯ NO ◯	Hepatitis C	YES ◯ NO ◯	Excessive Thirst	YES ◯ NO ◯
Hemophilia	YES ◯ NO ◯	Allergies or Hives	YES ◯ NO ◯	Emphysema	YES ◯ NO ◯	Mitral Valve Prolapse	YES ◯ NO ◯	Fainting/Dizzy Spells	YES ◯ NO ◯	Swelling of Ankles/Feet/Hands	
Heart Attack	YES ◯ NO ◯	Bruise Easily	YES ◯ NO ◯	Chemotherapy	YES ◯ NO ◯	Rheumatism	YES ◯ NO ◯	Heart Pacemaker	YES ◯ NO ◯		YES ◯ NO ◯
Ulcers	YES ◯ NO ◯	Rheumatic Fever	YES ◯ NO ◯	Epilepsy or Seizures	YES ◯ NO ◯	Hepatitis A (infect.)	YES ◯ NO ◯	Recent Weight Loss	YES ◯ NO ◯	Cold Sores/Fever Blisters	
Asthma	YES ◯ NO ◯	Glaucoma	YES ◯ NO ◯	Blood Disease	YES ◯ NO ◯	Herpes	YES ◯ NO ◯	AIDS	YES ◯ NO ◯		YES ◯ NO ◯

Do you have any disease, condition, or medical problem not listed above YES ◯ NO ◯

If yes, please list: _____

For Women

Are you pregnant? YES ◯ NO ◯

Are you nursing? YES ◯ NO ◯

Are you taking any birth control pills? YES ◯ NO ◯

NOTES:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

Patient Signature (Parent or Guardian) _____ Date _____

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Dental History

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Name: _____ Date: _____

Reason for today's visit: _____

Date of last dental visit: _____ Purpose of that visit? _____

Date of last teeth cleaning: _____ Date of last full mouth x-rays: _____

Our goal is to make your experience in our office exactly how you want it to be. Please complete the following so we can make you as comfortable as possible.

What concerns you most about your mouth? _____

Rate, in order of value from 1 to 4 (with 1 being the most important), what is most important to you in your dental care:

_____ Preventive Care

_____ Only what is necessary at the time (Cost is important)

_____ Comprehensive, Quality Care

_____ Other _____

Mark "YES" or "NO" next to each item.

Do you have dental exams on a regular basis? Every _____ months YES ◯ NO ◯

Do you think you have cavities in your mouth now? YES ◯ NO ◯

Are any of your teeth sensitive to:

- cold? Where? _____ YES ◯ NO ◯
- hot? Where? _____ YES ◯ NO ◯
- sweets? Where? _____ YES ◯ NO ◯
- biting or chewing? Where? _____ YES ◯ NO ◯

Are you concerned about:

- Replacing missing teeth? YES ◯ NO ◯
- Eliminating any disease present in your mouth? YES ◯ NO ◯
- Gum Disease? YES ◯ NO ◯
- Bad Breath? YES ◯ NO ◯
- The appearance of your smile? YES ◯ NO ◯
- Jaw Pain (TMJ)? YES ◯ NO ◯

Are your teeth wearing down? YES ◯ NO ◯

Is keeping your natural teeth important to you? YES ◯ NO ◯

Rate your level of apprehension you have regarding dental treatment. (10 being the most apprehensive and 1 being the least)

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

When Dr. Andow reviews your treatment plan with you would you like to know (please mark one):

◯ The big picture of what needs to be done ◯ All the treatment details along the way

NOTES:

Panorama Dental Building • 9025 E. Mineral Cir., Suite 101 • Centennial, CO 80112 • (303) 799-1525 • www.andowdental.com

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OFFICE AND FINANCIAL GUIDELINES

Thank you for selecting our office for your dental care. In an effort to keep your dental costs down while maintaining the highest level of professional care, the following guidelines have been established.

GENERAL INFORMATION

Your customized treatment plan will be outlined and financial obligations discussed. If treatment is delayed, this initial plan may vary. Quoted fees are the best estimate for the discussed treatment and are guaranteed for 45 days. Because the sequence of your treatment is extremely critical, your appointments will be reserved exclusively for you.

We have established the following methods of payment for your use:

1. Cash or Check
2. Visa, MasterCard, Discover and American Express
3. CareCredit Financing

Your dental care is not complete until your financial obligations are met. A $30 fee will be charged to your account for any returned check. Any costs and fees incurred in an effort to enforce payment shall be your responsibility.

YOUR DENTAL BENEFIT

Most likely, your employer (or past employer) is providing you with a dental reimbursement plan. As such, your dental coverage is a contract between you and your insurance company. You will always receive quicker responses, quicker payments and better payments if you contact your insurance company directly with specific questions.

As a courtesy to you, we will do our best to help you get the maximum benefit possible from your provider. Today, dental insurance is not designed to cover all the cost of dental care but is used to help offset the cost of care.

Most importantly, we will do everything we can to help you achieve that healthy, beautiful smile you deserve.

PRIVACY STATEMENT

Any personal information you provide us including general, health and financial information will be held in strict confidence. All detailed guidelines are in our Notice of Privacy Practices.

REFERRALS

If you are satisfied and appreciate the dental care you are receiving from our office, please tell your family, friends and co-workers about us. Our greatest reward is knowing that you are pleased with the services we provide.

By signing below, I certify that I have read and understand the above. I also acknowledge receiving a copy of this office's Notice of Privacy Practices.

_____	_____
Print name	Date
_____	_____
Signature (or parent, if minor)	Witness