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9760 Grant St. Suite 100, Thornton, CO 80229

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Perferred Approximated Times: Morning Afternoon Evening Any Time M T W T F S Address: Street City State Zip Code Femail HEALTH INFORMATION Date of Last Dental Visit: Reason for This Visit: Have you ever had any of the following? Please check those that apply: Alleugies Cancer Heal Injuries Nervous Disorders Stomach Problems Diabetes Heart Mierral Presentes Stown Disorders Stomach Problems LIST MEDICATIONS Alleugies Cancer Heal Injuries Nervous Disorders Stomach Problems Epilepsy Heart Marrary Presents Stown Stomach Problems Presents Problems Problems Stomach Problems Infured Injuries Presents Problems Problems Problems Stomach Problems Problems Infured Injuries Problems Problem	POINTE	- I	Iome Phone	Mobile Phone	Wor	k Phone	Ext.	Best	Time to	Call			
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Yellow Pages Newspaper School Work Other													
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Name of person or office referring you to our practice:	Yellow Pag	ges	Newspaper		School		Work	Other					
	Name of person	or office re	eferring you to our pr	actice:									

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The Following is for: The Pati	ent's Spouse	The Person Responsibl	e for Payment					
Name:								
Male Fe	emale	Single	Married	Child	Other			
Phone:								
Home Phone	Mobile Phone	Work Phone	Ext	. Best	Time to C	Call Social Security #	Birth Date	
						A		
Street						Apartment	#	
City			Sta	te			Zip Code	
EMPLOYMENT IN	NFORMAT	TION						
The Following is for: The Pati	ent	The Person Responsibl	e for Payment					
Employer Name:			Occup	ation:				
Address:								
Street			City			Stat	e Zip Code	
INSURANCE INFO	ORMATIO	N						
Primary						Is Insured a Patient?	Yes	No
Name of Insured: Last Name		First Name			MI	Patient's Relat	ionship to In	sured:
	ID:		Gra	oup #:	1/11	Self	Spouse	Child
Insured's Birtii Date.	ID :	π				Other		
Insured's Employer Name:			Inst	irance Plai	n Name:			
Address:			Ado	dress:				
Street				Stree	et			
City	State Z	ip Code		City		Stat	e Zip Code	
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Secondary Name of Insured:						Is Insured a Patient?	Yes	No
Last Name		First Name			MI	Patient's Relat	•	
Insured's Birth Date:	ID :	#:	Gro	oup #:		Self Other	Spouse	Child
					NI	— Other		
Insured's Employer Name:			Inst	ırance Pla	n Name:			
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City	State Z	ip Code		City		Stat	e Zip Code	
CONSENT FOR S	ERVICES							
As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental			ancial arrangement estimate listed for iod of six months en professional six professional arrangement of the six professional arrangement six professional six professional arrangement six professional six prof	ents are satisfi r this dental ca from the date ervices rende to pay theref or, or his assig five (5) days o eatment and	ed. va me that sh fur be ore the inee, at f billing	credit shall be extended. I fulue of said services shall be a, in writing, within the time for at a waiver of any breach of a all not constitute a waiver of and ther agree to pay all costs and instituted hereunder. I grant my permission to you at home or at my work to discust and agree to their content.	as billed unless of payment thereof. any time or condi any further term or di reasonable attor or your assignee uss matters related.	objected to, by I further agree ition hereunder condition and I rney fees if suit e, to telephone
office cannot render services on the assum will be paid by an insurance company.		.,					1	
A service charge of 11/2% per month (18	% per annum) on the	on the Signature of Guarantor of Payment/Responsible Party Date Relationship to Patient						p to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

,	, have received a copy of this office's Notice of Privacy Practices.
{Signature}	
{Date}	
	HIPPA Release Authorization
l,	give Highpointe Dental permission to leave a message on my
phone at the following numb	er
	nission to discuss my dental treatment with Relationship to patient
Signature	
Date	