ACACIA DENTAL GROUP, PC
MARK R. NOVELEN, DDS
SOGAND FARTASH NAINI, DDS

3627 S. PENNSYLVANIA ST
ENGLEWOOD, CO 80113
(303) 781-0624

PATIENT

Name _____ **Today's Date** _____
Last **First** **MI**

Date of Birth _____ **Age** _____ **Gender at Birth** ☐ **M** ☐ **F**

Address _____
City **State** **Zip**

Cell ( ) _____ **Home ( )** _____ **Work ( )** _____

Email _____ **SSN** _____ **DL#/State ID#** _____

Whom may we thank for referring you _____

Occupation _____ **Name of Employer**_____

Name of Spouse (Parent if Minor) _____

PATIENT HEALTH HISTORY

Reason for today's visit _____

Please circle if you have any of the following:

Bad Breath	Clicking or Popping Jaw	Loose Teeth	Sensitivity to Biting
Bleeding Gums	Dental Anxiety	Periodontal Treatment	Sensitivity to Cold
Broken Fillings	Food Collection Between Teeth	Sores or Growths	Sensitivity to Heat
Broken Teeth	Grinding Teeth		Sensitivity to Sweets

MEDICAL HISTORY

Are you under a Doctor's care at this time? Y N If yes, please specify: Dr. Name: _____
I have/had a drug or alcohol addiction? Y N Dr. Number: _____
Do you premedicate before dental visits? Y N
Have you ever had a blood transfusion? Y N If yes, list the approximate date: _____
Have you ever had a surgical procedure? Y N Please list: _____
Are there any other health problems of which we should be advised? Please specify**:** _____
_____

Please circle if you have/had any of the following:

AIDS	Circulatory Problems	Heart Murmur	Nervous Problems	TMD or TMJ
Anemia	Cortisone Treatments	Heart Surgery	Pace Maker	Tobacco/Cannabis Habit
Angina	Cosmetic Surgery	Hemophilia	Phen-Fen	Tonsillitis
Arthritis	Coughing up Blood	Hepatitis A,B or C	Psychiatric Care	Tuberculosis
Artificial Heart Valve	Cough, Persistent	High Blood Pressure	Respiratory Disease	Ulcer
Artificial Joints	Diabetes	HIV Positive	Rheumatic Fever	Venereal Disease
Asthma	Dizzy Spells	Jaundice	Scarlet Fever	Other _____
Back Problems	Emphysema	Jaw Pain	Shortness of Breath	_____
Bleeding Problems	Epilepsy	Kidney Disease	Sinus Trouble	
Blood Disease	Fainting	Liver Problems	Skin Rash	
Cancer	Glaucoma	Low Blood Pressure	Stroke	
Chemical Dependency	Headaches	Lung Disease	Swelling of feet/ankles	
Chemo Therapy	Heart Attack	Mitral Valve Prolapse	Thyroid Problems	

Please list any medications you are currently taking _____

Please circle if you have any allergic reactions to the following:

Anesthetics	Barbiturates	Iodine	Penicillin	Latex
Aspirin	Codeine	Local Anesthetic	Sulfa	Other _____

The above information is accurate and complete to the best of my knowledge. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to performing of x-rays and oral examination. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of patient (Parent if Patient is a minor) **Date**

A 48 hour notice is required for cancellation or $50.00 will be charged per hour of scheduled appointment.

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RESPONSIBLE PARTY
(If same as patient, please check here) ☐
Name _____
Last **First** **MI**

Address _____

City _____ **State** ____ **Zip** _____

Cell ( ) _____ **Home ( )** _____

Work ( ) _____ **Email** _____

SSN _____ **Date of Birth** _____

Sex ☐ M ☐F DL#/State ID# _____

Emergency Contact

Name _____
Last **First** **MI**

Address _____

City _____ **State** ____ **Zip** _____

Phone ( ) _____

Alt. Phone ( ) _____

Relationship ☐ Spouse ☐ Parent ☐Other

INSURANCE INFORMATION

PRIMARY INSURANCE

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Insurance Phone _____

Insured's Name _____

Insured's SSN or ID _____

Date of Birth _____

Group Number _____

SECONDARY INSURANCE

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Insurance Phone _____

Insured's Name _____

Insured's SSN or ID _____

Date of Birth _____

Group Number _____

General Consent

1. I hereby consent to Dr. Novelen and his staff taking necessary diagnostic records so a thorough analysis of my dental needs may be completed. These include, but are not limited to, x-rays, study models and photographs. I further consent to the use of these diagnostic records for educational, promotional, and scientific purposes, including publication.
2. I understand that the estimated patient portion for treatment **will be collected at the time of treatment,** and that this estimate is based on the information provided by my insurance company. I understand that this is **only** an estimate and that final benefits are not determined until the claim is settled by my insurance company.
3. I understand that I am financially responsible for all charges, whether or not covered or paid for by my insurance company.
4. I herby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
5. I, the undersigned certify that I (or my dependant) have insurance coverage as indicated above and assign directly to Acacia Dental Group, PC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Responsible Party or Patient (Parent if Patient is a Minor) **Date**