Spring Creek Dental Associates

PATIENT INFORMATION

Name_____ Preferred _____
SS#_____ Birthdate_____
Address_____City_____State_____Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
E-Mail (optional)_____

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

DENTAL INSURANCE INFORMATION

Name of Insured_____Relationship to Patient_____
Birthdate_____ Soc. Sec# **or** ID#_____
Name of Employer_____Work Phone_____
Insurance Company_____Group#_____
Ins.Address_____City_____State_____Zip_____
Ins. Phone#_____

Do you have dual coverage? No Yes
If yes complete the following

Name of Insured_____Relationship to Patient_____
Birthdate_____ Soc. Sec#_____**or** ID#_____
Name of Employer_____Work Phone_____
Insurance Company_____ Group#_____
Ins. Co. Address_____City_____State_____Zip_____
Ins. Phone#_____

Patient's Health History

Name:_____ Birth Date:_____
Has another dentist treated you in the past? _____ Name:_____ Phone:_____
Medical Doctor's Name: _____ Phone:_____
Describe your general health: _____
Have you had or do you have any serious illness? _____ Past Surgery:_____
Undergone general anesthesia? _____ When? _____
Are you presently under a doctors care? _____ For what? _____
Are you presently taking any medications, including birth control? _____
List any medications and why you are taking them: _____

EMERGENCY CONTACT NAME:_____ NUMBER:_____ RELATION:_____
May we share your personal/financial information with them? Yes No

Have you had or do you now have any of the following?

Anemia or Bleeding disorder…..	☐ Yes	☐ No	Asthma, Tuberculosis, Breathing Problems	☐ Yes	☐ No
Diabetes……..	☐ Yes	☐ No	Cancer……..	☐ Yes	☐ No
Rheumatic Fever……	☐ Yes	☐ No	Hepatitis or HIV (AIDS) Positive……	☐ Yes	☐ No
High or low blood pressure……..	☐ Yes	☐ No	Artificial Joints……	☐ Yes	☐ No
Heart Disease……..	☐ Yes	☐ No	Taken Phen-Fen……	☐ Yes	☐ No
Heart Murmur……	☐ Yes	☐ No	Are you pregnant……	☐ Yes	☐ No

Do you have any allergies or adverse reactions to medications or drugs? _____
Do you know of any other information that might affect your dental treatment? _____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medication can affect dental treatment I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize the dentists of Spring Creek Dental and/or such associates or assistants as she/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility.

I understand that the administration of local anesthetic may cause an outward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely permanent numbness, and muscle soreness. I understand that there are risks associated with ALL dental treatments including, but not limited to: permanent numbness, pain, swelling, and unsuccessful treatment, etc. I understand that as a result of dental treatment including preventative procedures such as cleanings and basic dentistry, as well as fillings of all types, the teeth, gums, and surrounding areas may remain sensitive or even possibly quite painful both during and after completion of treatment.

CONSENT FOR TREATMENT I hereby grant authority to the dentist(s) in charge of the patient whose name appears on the *Health History Form* to administer any treatment or to administer such anesthetics, analgesics, sedatives, and nitrous oxide sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of the patient. I have read the above terms and conditions and consent for treatment and fully agree to their content.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signed:_____Date:_____Relationship:_____

Date	Changes	Initials
_____	_____	_____

Office Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful and to providing the highest quality dental services at a reasonable fee. Please understand that payment of your bill is necessary in order for us to provide treatment.

Patients with Dental Insurance

As a courtesy to our patients we prepare and process all insurance forms. However, having insurance does not release the payment from responsibility.

Our expectations of you as the owner of the policy are as follows:

1. Estimated patient portions must be paid at the time of service. This may include co-pays, deductibles, co-insurance and/or non-covered procedures.
2. You are responsible for educating yourself about the details of your policy which includes deductibles, yearly maximums, and policy exclusions.
3. If the insurance company does not pay our office **within 60 days**, it is your responsibility to pay using one of the payment methods listed below. The insurance policy belongs to you and we have no leverage to obtain payment.

A finance charge of 1.5% per month (annual percentage rate 18%) will be assessed on any unpaid balance over 60 (sixty) days regardless of insurance estimates. Insurance estimates are based on limited information provided to our office by your insurance company and is not a guarantee of coverage or payment.

Please Initial_____

Patients without Dental Insurance

If there is no insurance coverage, full payment is due at the time of service with one of the payment methods listed below.

Payment Options

For your convenience you may choose any of the following methods of payment:

- Cash
- Personal Check (postdated if necessary)
- Visa, MasterCard, Discover, American Express-Credit or Debit
- Care Credit (short-term plans are available with no interest). Credit approval must be received prior to treatment.

Broken & Missed Appointments

Please make every attempt to keep your scheduled appointment. If you must cancel or reschedule, kindly notify us a least 48 hours in advance. **There will be a $50 cancellation fee applied to your account for any appointment broken within 48 hours of your scheduled appointment time.**

Please Initial_____

X-ray Copies

Here at Spring Creek Dental we use digital x-rays. Digital x-rays use minimal radiation compared to traditional x-rays and are available upon request.

Minor Patients

The parent, guardian, or adult accompanying and signing all forms for a minor will be responsible for full payment. Parents or guardians must be present to authorize all dental treatment to minors.

Financial Agreement

I understand that I am financially responsible for all charges incurred by my dependents and myself whether or not covered by insurance. I hereby authorize Spring Creek Dental Associates to use the following signature for proof of signature on insurance claim forms for assignment of insurance payment and release of information. I agree to pay Spring Creek Dental Associates professional services rendered to me at the time of service. If my insurance pays less than estimated, I agree to pay any remaining balance within 30 (thirty) days of billing. I expressly agree to pay all costs of collection agency fees assessed at 40% of the total amount due as well as court costs and attorney fees if these terms are not met.

Signature of Parent or Responsible Party Print Name Date

Spring Creek Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgment

I, _____, have read and/or received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify)