INDIAN CREEK DENTAL

Today's Date _____

Patient Name Last_____First_____Middle Initial _____

Preferred Name _____

Sex: Male Female Birth date _____ Age_____

_____ ◯ ◯ Social Security # _____

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

RESPONSIBLE PARTY INFORMATION

Last_____ First_____Middle _____

Marital Status _____

Mailing Address _____

City_____ State _____ Zip _____ How Long?_____

Work Phone_____ Home Phone _____

Birth Date_____ Social Security _____ Driver's License #_____

Relationship to Patient _____ Occupation _____

DENTAL INSURANCE

Primary

Insured Name _____

Insurance Co. _____

Address _____

_____

Phone # _____

Employer _____

ID/ SSN # _____

Group # _____

Secondary

Insured Name _____

Insurance Co. _____

Address _____

_____

Phone # _____

Employer_____

ID/ SSN #_____

Group # _____

The patient 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 the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also 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. If legal action becomes necessary to collect fees due this office, the undersigned, agrees to pay all reasonable costs of such action including attorney's fees and collection costs and interest of 1.5% per month (18% per annum) on the unpaid balance 60 days from the treatment. I understand that credit reports may be obtained when appropriate. There may be a broken appointment fee of $50 if a 24 hour notice is not given to reschedule or cancel an appointment.

INDIAN CREEK DENTAL

PATIENT NAME: _____ DOB: _____ DATE CREATED: _____

1. Are you experiencing pain or discomfort? _____ Y N
2. Are you in good health? _____ Y N
3. Has there been a change in your general health within the past year? _____ Y N
4. Are you under the care of a physician? _____ Y N

   If so, what condition is being treated? _____

   Physician's Name: _____ Phone #: _____

   Address: _____
5. Have you been hospitalized or had a serious operation or illness within the past 5 years? _____ Y N
6. Do you have or have you had any of the following diseases or problems? Please circle:

- ☐ AIDS/HIV Positive
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Joint Artificial
- ☐ Heart Valve Asthma
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Chemotherapy (Cancer, Leukemia) Cold
- ☐ Sores/Fever Blisters
- ☐ Congenital Heart Defects/Lesions
- ☐ Cortisone Medicine
- ☐ Cough
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy Spells
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Disease Heart
- ☐ Failure
- ☐ Heart Murmur Heart
- ☐ Pacemaker Heart
- ☐ Surgery
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B (Serum)
- ☐ High/Low Blood Pressure
- ☐ Kidney Trouble
- ☐ Latex
- ☐ Liver Disease
- ☐ Metals
- ☐ Mitral Valve Prolapse
- ☐ Nervousness
- ☐ Pain in Jaw Joints Plastics
- ☐ Psychiatric Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease/Traits Sinus
- ☐ Trouble
- ☐ Stroke
- ☐ STD or VD (Syphilis, Gonorrhea) Thyroid
- ☐ Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers/Colitis Yellow
- ☐ Jaundice
- ☐ X-Ray or Cobalt Treatment

7. Are you taking any drug, medicine or herbal supplement? _____ Y N

   If so, what: _____
8. Are you allergic or have you reacted adversely to any drugs or medicines? _____ Y N

   If so, which drugs? _____

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Demoral
- ☐ Erythromycin
- ☐ Local Anesthetic
- ☐ Nembutal/Seconal
- ☐ Nitrous Oxide
- ☐ lidocaine or Marcaine
- ☐ Penicillin
- ☐ Percodan
- ☐ Other Antibiotics
- ☐ Scopolamine
- ☐ Sleeping Pills
- ☐ Tetracycline
- ☐ Valium

9. Have you had previous skin reactions to jewelry or know of an allergy to any metal? _____ Y N
10. Have you had any serious trouble associated with any previous dental treatment? _____ Y N
11. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? _____ Y N
12. Do you have a disease, condition, or problem not listed above that you think I should know? _____ Y N

    If yes, please explain: _____
13. **FOR WOMEN ONLY: ARE YOU PREGNANT?** _____ Y N

    If YES, what month? _____ Are you taking birth control pills? _____ Y N
14. Is there anything about your smile you don't like such as discolored teeth, crooked teeth, unsightly silver fillings, etc.? _____ Y N
15. Our doctors are accomplished cosmetic dentists. Would you like current information on smile improvement procedures they perform, such as bleaching, porcelain veneers, and tooth-colored restorations? _____ Y N

CONSENT: The undersigned hereby authorizes the Indian Creek Dental to take radiographs, 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 in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

PATIENT _____ DATE _____ DOCTOR _____

PARENT OR RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

Consent for Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name:_____ Social Security #: _____

Address:_____

Email: _____

Please list all telephone numbers where we can contact you:

_____ _____

_____ _____

List names of ALL people (e.g. spouse, parents, etc.) you authorize us to release your health information to, including copies of your records if needed:

1) _____ 2) _____

3) _____ 4) _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice ac- companies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation of this Consent will not affect any action we Indian Creek Dental had taken in reliance on this Consent before we received your revocation, from that point, we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE AND DISCLOSURE:

I ,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

INDIAN CREEK DENTAL

Office Policies and Procedures

Financial Policy

Payment for Services rendered is due the day of treatment. We do our best to provide you with an accurate estimate of what your insurance is expected to pay based on the Information you and your insurance provides us. Occasionally the insurance Company will deny, delay, or reduce payment for Services based upon their specific criteria relating to your policy. Any remaining balance not paid by insurance within 90 days will be the patient' s responsibility. Balances extending after 120 days are to be sent to an outside collection agency unless an agreement was made between Office and patient.

Appointment Scheduling/Confirmation Policy

We will preschedule your next appointment with your consent according to recommended recall frequencies or next phase of treatment requirements. However, we require a verbal confirmation of every appointment within 24- 72 hours to reserve your appointment time. Without this confirmation, your appointment may be cancelled and given to another patient. Certain Saturday appointments may require a deposit to hold your appointment time for dental Treatment. Appointments with our specialists will require 50% deposit in advance to schedule the treatment.

Broken Appointment/Short Cancellation Policy

We understand that emergencies rarely occur but when they do this may preclude you from keeping your scheduled appointment. Cancellations or no-shows without proper notice make it difficult to fill the appointment time that was specially reserved for you. If you no-show or cancel your appointment without a proper 24-hour notice, you will be charged a $50.00 broken appointment fee. Some Saturday appointments will a non-refundable 50% deposit to schedule.

Warranty Policy

Indian Creek Dental is pleased to offer a generous warranty for your treatment. We offer a five-year warranty on crowns, on lays and bridges. We offer a two-year warranty on composite fillings, night-guards and appliances. For the warranty to remain in effect, the patient must keep up with recommended cleanings at our office without exception. The warranty will apply to defects in materials only, and the patient may be required to pay for lab costs associated with a replacement. The warranty may be modified at the office's discretion.

If there are any questions regarding office policies or procedures, please contact the front office team. By signing below, you agree to abide by our office policies.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Submit