Salem Creek
FAMILY DENTAL

Welcome to our Office. We appreciate the confidence you place with us to provide dental services. Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Last Name _____ First _____ M.I.____ Preferred Name_____ M or F

Street Address _____ City _____ State_____ Zip_____

Birthdate_____ Social Security No. _____ Email _____

Home phone _____ Cell_____ Work phone _____

Married Status: Single Married Divorce Widowed

How would you like to receive appt. reminders? (Mark any)

Home phone phone cell Text message E- mail

Employer _____ Phone #_____

In the event of an Emergency please contact:

1._____ Relationship _____ phone # _____

2._____ Relationship _____ Phone#_____

Person Responsible for Account _____ Relationship: _____

Whom may we thank for referring you? _____ Did you receive a mailer? _____

Primary Dental Insurance:

Insured's Name _____

Employer _____

Insurance _____

DOB _____ SS# _____

Subscriber ID# _____

Secondary Dental Insurance:

Insured's Name_____

Employer_____

Insurance_____

DOB _____ SS#_____

Sub. ID#_____

_____ _____

Patient's Signature/ If minor, Parent/Guardian Date

DENTAL HEALTH HISTORY
Confidential

Today's Date_____

Patient Name_____ Birthdate_____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit_____ Date of last dental care_____

Former Dentist_____ Date of last dental X-rays_____

Address_____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit_____

Have you had any serious illnesses or operations?_____ If yes, describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex_____
- ☐ Other_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/he staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we discuss your medical condition with any member of your family? **YES NO**

If YES, please name the members allowed:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient Name (PRINT): _____

Signature (Guardian): _____ Date: _____

Witness: _____ Date: _____

Salem Creek
FAMILY DENTAL

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you can obtain optimum oral health. The following is statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express. Outside financing is available upon request and approval.

Do you have insurance?

- As a courtesy we will fill your insurance claims for you. **Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated.** Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make your estimate as accurate as possible.
- I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims. We must emphasize that your individual insurance policy is a contract between you, your employer, and you insurance company, and our office is not part of that contract.
- **Our office is committed to providing the best treatment for our patients and we charge what is usual and customary for out area.** You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- I authorize the release of information to insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons (worker's comp, accident, etc.)
- **We ask that you pay the deductible and co-payment**, which is the estimated amount not covered by insurance company, by cash, check, MasterCard, Visa, Discover, or American express **at the time we provide the service to you**.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount. We will, however, continue to work with you and your insurance company to expedite your reimbursement.
- We will cooperate fully with the regulations and requests of your insurance company to assist with the claim to being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- When being referred to a specialist, I am responsible for making sure that the doctor is on my insurance plan.
- A fee of $35 will be incurred for each returned check. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal chares up to 35%.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: I, the undersigned, give Salem Creek Family Dental, its employees and/or agents "express Prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone or text message) or email, for the purpose of treatment, insurance and/ or payment, and messages may be left on any answering services at such given numbers.

CONSENT:

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, collection charge, and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at the number you provide including calls to mobile/cellular or similar devices for any lawful purpose.

Patient Signature (Guardian) _____ Date _____