

SPRING VALLEY DENTAL GROUP

PATIENT INFO: Mr. Mrs. Ms. Miss Dr. **Patient Name:** _____

Social Security #: _____ Date of Birth: _____ Child Single Married Other

Address: _____ Male Female

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell _____

Nearest Relative NOT in your home _____ Relationship _____ Phone # _____

Patient Employer or School _____ Occupation: _____

Drivers License # _____ E-mail Address: _____

How did you hear about us? Phone Book (which one?) _____ Newspaper

Sign/Drive By Friend (name) _____ Other: _____

Responsible Party and/or Primary Insurance Information: Please notify us if there is secondary dental insurance.

Relationship to Patient: Self (IF SELF, SKIP TO INS INFO) Spouse Parent Other: _____

Responsible Party's name or Policy Holder's name _____

Date of Birth: _____ Social Security #: _____ Driver's License# _____

Address: _____ Single Married Other _____

City: _____ State: _____ ZIP: _____ Male Female

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ ZIP: _____

Insurance Plan Name: _____ Insurance Group No. _____

Insurance Plan Phone: _____ Insurance/Subscriber ID No. _____

Insurance Plan Address: _____ City: _____ State: _____ ZIP: _____

PAYMENT OPTIONS

- ▶ Cash, Credit, Debit, Check with a valid Driver's License. Balances are due at the time of service, unless prior arrangements are made thru PFC and / or CareCredit. (We will be glad to help you with the application.)
- ▶ Three - Six Months Same as Cash: Through PFC and CareCredit for our patients who qualify.
- ▶ Extended Payment Plans thru CareCredit, (low interest rate charged to patient). We will be glad to help you with the application.

PAYMENT POLICIES

- ▶ Fees are determined by the services required. You may discuss any fees with your Doctor's receptionist.
- ▶ Balances are due at the time of service. If you are insured, your estimated co-payment is due at the time of service. We will submit your claim, however; you are responsible for any remaining balance, after the insurance pays.
- ▶ Your account, if any balance is due after insurance pays, is due by the 20th of the month. A \$5.00 late fee will incur if received 3 days late.

COLLECTIONS POLICY

If a collection agency is used to recover any unpaid balance due to us, the responsible party is liable for all charges incurred. You will be charged \$25.00 for a returned check with insufficient funds. \$10.00 for each time a check is re-processed. Any patient that has a returned check will be placed on a cash/credit/debit status.

APPOINTMENT CANCELLATION POLICY/BROKEN APPOINTMENTS/OR *LATE FOR APPOINTMENTS/DISMISSAL OF PATIENT:

Failure to give 24 hours notice may result in a charge of \$50.00/per hour of scheduled time. Your appointment has been reserved exclusively for you. Please provide ample notification if you need to change your appointment. Your appointment time may be appreciated by another patient. *You may be charged \$50.00 and rescheduled if you are 15 minutes late. **PLEASE RESPECT OUR TIME AND THE PATIENTS SCHEDULED AFTER YOU.** You will be dismissed as a patient if you consistently break appointments or consistently arrive late for appointments.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: _____

PATIENT'S NAME _____

AGE _____

DATE OF BIRTH _____

IF MINOR---PARENT'S NAME: _____

DENTAL HISTORY

Have you been having any specific problems? Yes No Describe: _____

Last dental visit? _____ Purpose: _____ Last complete exam: _____

Has fear of discomfort kept you from regular visits? Yes No

Your dental health? Good Fair Poor Do you feel you have Decay? Yes NO Gum Disease? Yes No

Home Care: Brush? Yes No Floss? Yes No Other: _____ Do your gums ever bleed? Yes No

How do you feel about your smile? Good Fair Poor

Is there anything that you would like to change about your smile? _____

Are you interested in whitening your teeth? _____ Are you interested in straightening your teeth? _____

MEDICAL HISTORY

Please answer each question and mark yes or no where indicated.

Name of your Physician: _____ If you do not have a physician, please write none.

Last Exam _____ Phone Number: _____ Please call back w/ number, if unknown.

(Women) Are you pregnant? Yes No Expected delivery date _____ Are you taking birth control? Yes No

Are you under a doctor's care now? Yes No If so, for what reason? _____

Are you taking any pills, medications, or drugs? Yes No Please list: _____

Do you have or have you ever been treated for any of the following? Please check all that apply.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Asthma / Inhaler | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Radiation/Chemo Treatment |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergy to medications _____ | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hormone Replacement Tx | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy (anesthetic) | <input type="checkbox"/> Chewing Tobacco | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergy (other) _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Angina/Chest Pains | <input type="checkbox"/> Epilepsy/Convulsion | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anti-Depression Treatment | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis (Type) _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valves Date: _____ | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Artificial Joints Date: _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Aspirin Tx/Blood Thinner | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcer |

Current use any type of tobacco product? None Cigarettes Cigar Pipe

Have you used any street/illicit drugs in the past? Yes No

Because of anesthetic, we need to know if you currently use any street/illicit drugs, if so please list: _____

Consent for Services/Assignment of Benefits: After my exam, I authorize the doctor to perform the necessary treatment as needed. I authorize the release of any information relating to dental treatment to third party payers and/or other health practitioners for myself or my dependents by Spring Valley Dental Group / provider. I authorize my doctor to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for my dependents or myself. I understand that all insurance payments will be made directly to the doctor, unless otherwise specified by me.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENTS.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: _____