SPRING VALLEY DENTAL GROUP WELCOMES YOU TO OUR PRACTICE!

Our goal is to help you have healthy teeth and provide the best dental care possible. Please help us by providing the following information:

ABOUT YOU

Name: _____

Address: _____

City/State/Zip: _____

Nickname/Prefer: _____

Home #: _____ Work #: _____

Mobile #: _____ May we contact via Mobile? ☐ Y ☐ N

E-mail Address: _____

Birth date: _____/ _____/ _____ Age: _____ Gender: ☐ M ☐ F

Employer: _____

Occupation: _____

Social Security #: _____

Marital Status: _____ Spouse's Name: _____

In case of emergency please contact *(name, phone & relationship)*:

YOUR DENTAL HISTORY

Why have you come to see us today? _____

_____

Is there anything you would like to change about the appearance of your teeth or smile? _____

_____

Date of last Dental Exam: _____/ _____/ _____

Has your dental care been:

☐ Regular (every 6 mo.) ☐ Sporadic ☐ Emergencies Only

Are you apprehensive about dental treatment? ☐ Y ☐ N

Do your gums bleed when you brush or floss? ☐ Y ☐ N

Are you interested in whitening and/or straightening your teeth? ☐ Y ☐ N

Whom may we thank for referring you to our office?

MEDICAL HISTORY

Heart Failure	Y	N	Stroke	Y	N	Hay Fever	Y	N	Arthritis	Y	N
Heart Attack	Y	N	Aneurysm	Y	N	Sinus Problems	Y	N	Artificial Joints	Y	N
Angina/Chest Pain	Y	N	Epilepsy/Seizures	Y	N	Allergies	Y	N	Osteoporosis/Meds	Y	N
High Blood Pressure	Y	N	Frequent Headaches	Y	N	Asthma	Y	N	Cancer	Y	N
Heart Murmur	Y	N	Fainting/Dizziness	Y	N	Emphysema	Y	N	Chemotherapy	Y	N
Mitral Valve Prolapse	Y	N	Glaucoma	Y	N	Tuberculosis (TB)	Y	N	Radiation	Y	N
Heart Defect	Y	N	Psychiatric Treatment	Y	N	Difficulty Breathing	Y	N			
Artificial Heart Valve	Y	N	Drug/Alcohol Abuse	Y	N	Sleep Apnea	Y	N	Herpes	Y	N
Rheumatic Fever	Y	N	Auto Immune Disorder	Y	N	CPAP	Y	N	HIV/AIDS	Y	N
Irregular Heart Beat	Y	N	Blood Transfusion	Y	N				Venereal Disease	Y	N
Pacemaker	Y	N	Hemophilia	Y	N	Liver Disease	Y	N	Recreational Drugs	Y	N
Heart Surgery	Y	N	Leukemia	Y	N	Hepatitis	Y	N	Tobacco Use	Y	N
Bacterial Endocarditis	Y	N	Anemia	Y	N	Kidney Disease	Y	N	**WOMEN**:		
Other Heart Problems	Y	N	Sickle Cell Disease	Y	N	Organ Transplant	Y	N	Are you pregnant?	Y	N
If Y, list: _____			Abnormal Bleeding	Y	N	Diabetes	Y	N	If Y, when due? _____		
_____			Blood Thinners	Y	N	Thyroid Problems	Y	N	Are you nursing?	Y	N
_____			Acid Reflux	Y	N	Ulcers	Y	N	Birth control pills?	Y	N

Physician's Name, Address & Phone: _____

Date of Last Physical Exam: _____

ALLERGIES: Are you allergic to Penicillin, Aspirin, Codeine, Dental Anesthetics, Latex, or any other medication or substance? ☐ Yes ☐ No

If yes, please list: _____

MEDICATIONS: Are you taking any medications, herbs or supplements? ☐ Yes ☐ No

If yes, please list: _____

Have you ever been told to take a pre-medication prior to dental appointments? ☐ Yes ☐ No

Do you have any medical concern or condition not listed? ☐ Y ☐ N If Yes, Explain: _____

To the best of my knowledge, all of the preceding is correct. If I ever have a change in my health, medication, or medical condition, I will inform the dentist at my next appointment. I authorize release of any information to my insurance company and/or other health care providers involved in my treatment.

Patient Signature: _____ **Date**: _____/ _____/ _____

Notes: _____

Doctor's Signature: _____ **Date**: _____/ _____/ _____

INSURANCE AND BILLING INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT

☐ Self (skip this section) ☐ Other

Relationship to the Patient: _____ Work Phone #: _____

Name: _____ Home Phone #: _____

Address: _____ Cell Phone #: _____

_____

Employer: _____ Birth date: _____ / _____ / _____ Age: _____

Occupation: _____ Gender: ☐ Male ☐ Female

Social Security #: _____ Marital Status: _____ (*Spouse's Name*_____)

IF YOU HAVE DENTAL INSURANCE

If you have dental insurance, we will be happy to assist you in obtaining benefits, and will *estimate* your benefits based upon your policy information. It is important for you to understand insurance plans vary greatly from plan to plan and/or from employer to employer, so we cannot be certain what benefits your insurance company will pay. Any questions over coverage is ultimately the responsibility of your insurance company.

PRIMARY

Patient's Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: _____

Address: _____

_____

Birth date: _____ / _____ / _____

Social Security #:_____

Insured's Employer: _____

Group #: _____

Subscriber/Member ID#: _____

Ins. Co. Address: _____

Ins. Co. Telephone: _____

SECONDARY

Patient's Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: _____

Address: _____

_____

Birth date: _____ / _____ / _____

Social Security #:_____

Insured's Employer: _____

Group #: _____

Subscriber/Member ID#: _____

Ins. Co. Address: _____

Ins. Co. Telephone: _____

ACCOUNT AGREEMENT

As the person responsible for this account, I understand that I am responsible for payment of services rendered. Payment is due at the time of service unless other written arrangements have been made. I hereby authorize payment of insurance benefits directly to Spring Valley Dental Group, and understand that any disparity in coverage is a matter between my insurance company and me. I understand that any balance not paid within 90 days from the date services are rendered may be subject to finance charges. I understand that I will be assessed a fee of $25 for any returned check payments. In the event of non-payment, you will be responsible for any collection and legal fees associated with the collection of the balance due. The collection fee is 50% of the total balance and will be added to the account if it is turned over to an outside agency. For your convenience, we accept cash, personal checks, MasterCard, VISA, Discover, American Express and Care Credit.

Patient Signature: _____ Date: _____ / _____ / _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This notice is intended to inform you about our practices related to your medical/dental records. It will explain how we may use and disclose your information, our obligations related to the use and disclosure of your information, and your rights related to any medical/dental information that we have about you.

USE AND DISCLOSURE OF MEDICAL/DENTAL INFORMATION:

For Treatment: To provide you with dental treatment or services, we may need to use or disclose information about you to personnel involved in your treatment. For example, a dentist may need to consult with a physician regarding your condition while providing dental care.

For Payment: We may use and disclose your dental and medical information to bill and receive payment for the treatment that you received. For example, we may use or disclose your medical information to your insurance company about a service you received from Spring Valley Dental Group, so that your insurance company can pay us or reimburse you for the service.

For Communication: We may use your dental and health information to remind you of an appointment or treatment. For example, we may need to remind you or disclose updated dental and health information to you regarding an upcoming appointment **via text, email or voicemail**.

For Health Care Operations: We can use and disclose medical information about you for our operations. For example, we may use or disclose medical information about you to evaluate our staff's performance in caring for you.

USES AND DISCLOSURES OF MEDICAL INFORMATION THAT DO NOT REQUIRE YOUR AUTHORIZATION:

We can use or disclose health information about you without your authorization when there is an emergency, when we are required by law to treat you, or when we are required by law to use or disclose your health information without your authorization in any of the following circumstances:

- When it is required by federal, state or other law;
- When it is needed for public health activities;
- When reporting information about victims of abuse, neglect, or domestic violence;
- When disclosing information for the purpose of health over site activities;
- When disclosing information for judicial and administrative proceedings;
- When disclosing information for law enforcement purposes;
- When disclosure is necessary to comply with worker's compensation laws or purposes.

OTHER USES OR DISCLOSURE:

If you provide us with written authorization to use or disclose your health information, you can change your mind and revoke your authorization at any time, as long as you revoke your authorization in writing. If you revoke your authorization, we will no longer use or disclose your information, but we will not be able to take back any disclosures that we have already made.

YOUR RIGHTS WITH RESPECT TO HEALTH/DENTAL INFORMATION:

Right to Inspect and Copy Your Health/Dental Information: you have the right to inspect and copy your health/dental information, with certain exceptions. If you request copies of information, we may charge a fee for costs associated with your request, including the cost of copies, mailing, or other supplies.

Right to Request Information in Certain Form and Location: You have the right to request information in a certain form or at a specific location. For instance, you can request that we not contact you at work. The request must tell us how and/or where you want to receive information. We will accommodate reasonable requests.

Right to Request Restrictions: You have the right to request that we restrict any use or disclosure of your health/dental information. If we agree to your restriction, we will comply with your request. For example, a patient who does not want his or her physician to share health information with other physicians involved in his or her care may request to restrict such disclosure. We are not required to accept any restriction that you request.

We reserve the right to change or modify the information contained in this Notice. Any changes that we make will comply with appropriate federal, state or other laws.

RELEASE OF INFORMATION:

I authorize the release of information including the diagnosis, records; rendered to me and claims information. This information may be released to the following individuals:

_____

Print the names of the individuals covered by the release

I have received the Spring Valley Dental Group Notice of Privacy Practices.

_____

Patient or Guardian Signature

_____

Patient Name (Please Print)

_____

Date