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 ____

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

☐ AIDS/HIV	☐ Asthma / Inhaler	☐ High/Low Blood Pressure	☐ Radiation/Chemo Treatment
☐ Alcoholism	☐ Blood Disease	☐ High Cholesterol	☐ Respiratory Problems
☐ Allergy to medications____________	☐ Cancer	☐ Hormone Replacement Tx	☐ Rheumatic Fever
☐ Allergy (anesthetic)	☐ Chewing Tobacco	☐ Kiidney Trouble	☐ Seizures
☐ Allergy (other) _________________	☐ Diabetes	☐ Liver Disease	☐ Sexually Transmitted Disease
☐ Angina/Chest Pains	☐ Epilepsy/Convulsions	☐ Migraines	☐ Sinus Problems
☐ Anti-Depression Treatment	☐ Excessive Bleeding	☐ Mitral Valve Prolapse	☐ Stroke
☐ Arthritis (Type)_________________	☐ Heart Disease	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Artificial Heart Valves Date: __________	☐ Nervous Disorders	☐ Tuberculosis	☐ Tobacco
☐ Artificial Joints Date: __________	☐ Heart Murmur	☐ Osteoporosis	☐ Tumors
☐ Aspirin Tx/Blood Thinner	☐ Hepatitis	☐ Pacemaker	☐ 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:_______________