

## Welcome to Clear Creek Dental

Name \_\_\_\_\_ Date \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ E-mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Group# \_\_\_\_\_

Spouse or Parent Name \_\_\_\_\_

Subscriber's Social Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Person to contact in case of emergency? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Please read and sign the following:

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I authorize payment by my insurance company directly to *Clear Creek dental*. I understand that I am responsible for all costs of dental treatment regardless of what my insurance company pays. I hereby authorize *Clear Creek Dental* to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right of *Clear Creek Dental* to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If payments are not received by agreed upon dates, a 1.5 % late charge (18% APR) may be added to my account.

I have received a copy of this office's Notice of Privacy Practices

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Medical History**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? If yes, please explain \_\_\_\_\_

Have you ever been hospitalized or had major operation? If yes, please explain \_\_\_\_\_

Have you ever had a serious head or neck injury? If yes, please explain \_\_\_\_\_

Are you taking medications, pills or drugs? If yes, please explain \_\_\_\_\_

Do you take, or have taken, Phen-Fen or Redux? \_\_\_\_\_

Are you on a special diet? \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_ Do you use controlled substances? \_\_\_\_\_

**Women:**

Are you pregnant/trying to get pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ taking oral contraceptives? \_\_\_\_\_

**Are you allergic to any of the following?**

Aspirin\_\_\_Penicillin\_\_\_Codeine\_\_\_Acrylic\_\_\_Metal\_\_\_Latex\_\_\_Local anesthetic\_\_\_

Other, please explain \_\_\_\_\_

**Do you have, or have had, any of the following? Please check only the ones that apply.**

- |                           |                              |                              |                          |
|---------------------------|------------------------------|------------------------------|--------------------------|
| Aids/HIV positive___      | Breathing Problem___         | Easily Winded___             | Heart Attack/Failure___  |
| Alzheimer's disease___    | Bruise Easily___             | Emphysema___                 | Heart Murmur___          |
| Anaphylaxis___            | Cancer___                    | Epilepsy___                  | Heart Pacemaker___       |
| Anemia___                 | Chemotherapy___              | Excessive Thirst___          | Heart Trouble/Disease___ |
| Angina___                 | Chest Pains___               | Fainting Spells/Dizziness___ | Herpes___                |
| Arthritis/Gout___         | Cold Sores/Fever___          | Frequent Cough___            | Hemophilia___            |
| Artificial Heart Valve___ | Congenital Heart Disorder___ | Frequent Diarrhea___         | Hepatitis A, B or C___   |
| Artificial Joint___       | Convulsions___               | Frequent Headaches___        | High Blood Pressure___   |
| Asthma___                 | Cortisone Medicine___        | Genital Herpes___            | Hives or Rash___         |
| Blood Disease___          | Diabetes___                  | Glaucoma___                  | Hypoglycemia___          |
| Blood Transfusion___      | Drug addiction___            | Hay Fever___                 | Irregular Heartbeat___   |

Kidney problems___	Renal Dialysis___	Stroke___	Pain in Jaw Joints___
Leukemia___	Rheumatic Fever___	Swelling of Limbs___	Parathyroid Disease___
Liver Disease___	Rheumatism___	Thyroid Diseases___	
Low Blood Pressure___	Scarlet Fever___	Tonsillitis___	
Lung Disease___	Shingles___	Tuberculosis___	
Mitral Valve___	Sickle Cell Disease___	Tumors or Growths___	
Psychiatric Care___	Sinus Trouble___	Ulcers___	
Radiation Treatments___	Spina Bifida___	Veneral Disease___	
Recent Weight Loss___	Stomach/Intestinal Disease___	Yellow Jaundice___	

**Have you ever had any serious illness not listed above? If yes, please explain**

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**Signature of Patient, Parent, or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

CLEAR CREEK DENTAL

Financial Policy

Dear Valued Patient:

In order to keep fee increases to a minimum and continue to provide the best quality care for our patients, our dental office will be implementing a new financial payment policy.

We now ask that patients pay for their treatment with one of the following options at the time of service:

- Cash
- Check
- Credit card- Visa, MasterCard, American Express, Discover
- Capital One or Care Credit

**Patients with Dental Insurance:** We will continue to submit your insurance. However, we ask that you pay your insurance co-payment at the time of service. Insurance co-payments may change according to the procedures performed and your policy that you have with your employer. We cannot be responsible for services not covered or balances that have not been paid by your insurance. *Legally you are responsible for your account regardless of your balance. Please be certain of your commitment to our office prior to starting any dental treatment.*

**Preventive-** co-payment is contingent upon individual policies per your employer

**Basic-** 20% to 30 % is required

**Major-** 50% to 60 % is required

Note: Any insurance plan that pays directly to the patient requires payment in full at the time of service, unless prior financial arrangements have been made.

**Truth and Lending:** Late charges or finance charges will be assessed if payment is not received by the 20<sup>th</sup> of each month. The amount of the late charge is a minimum of \$5.00 with a maximum of \$20.00. Finance charges are assessed on all accounts with balances not paid within 60 days at a rate of 1.25%.

We appreciate your understanding of this policy. We look forward to continuing to serve you and your family's dental health needs.

CLEAR CREEK DENTAL

*Appointments are reserved especially for you. Kindly give our office a 48 hour notice if you need to reschedule or cancel. A \$50.00 broken appointment or late cancellation fee will be considered if less than 48 hour notice is not given. \_\_\_\_\_Initial*

*A \$25.00 fee will be charged for any duplication of x-rays that is requested. \_\_\_\_\_Initial*

\_\_\_\_\_

\_\_\_\_\_

Responsible party or Legal Guardian

Date