

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:

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

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 20th 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