CASTLE VALLEY DENTAL

Patient Information

Date: _____

Name_____ Male ☐ Female ☐

Address_____

City _____ State _____ Zip _____

Phone Home# _____ Work# _____ Cell# _____

Birth Date _____ Age _____

Responsible Party Information

Name: _____ Self ☐ Parent/Guardian ☐

Phone Home# _____ Work# _____ Cell# _____

Birth Date _____ SSN#_____Drivers License# _____

Email _____

Employer _____ Employer Phone# _____

Employer Address _____

_____

How did you find out about us? (If you were referred, please give the individuals name)

_____

Other Family Members
(in Same Household)

Name and Date of Birth:

_____ _____

_____ _____

_____ _____

Nearest Relative Information
(Not in same household)

Name _____ Birth Date _____

Address_____

Phone Home# _____ Work# _____ Cell# _____

Employer _____ Employer Phone# _____

Medical Information

Please check any of the following that may apply:

_____Allergies	_____Excessive Bleeding	_____Kidney Disease	_____Rheumatic Fever
_____Anemia	_____Fainting Spells	_____Latex Allergy	_____Seizures
_____AIDS/HIV Positive	_____Glaucoma	_____Liver Disease	_____Sinus Trouble
_____Arthritis	_____Hay Fever	_____Mental Disorders	_____Stomach Ulcers
_____Asthma	_____Head Injuries	_____Nervous Disorders	_____Stroke
_____Bleeding Disorders	_____Heart Disorders	_____Pacemaker	_____Tuberculosis
_____Blood Diseases	_____Heart Murmur	_____Penicillin Allergy	_____Tumors or Growths
_____Cancer	_____Hepatitis	_____Psychiatric Disorder	_____Venereal Disease
_____Cold Sores	_____High Blood Pressure	_____Radiation Treatment	_____ Other
_____Diabetes	_____Hip/Joint	_____Respiratory Disease	
_____Epilepsy	Replacement	_____Rheumatism	

If you checked "other "above, please explain: _____

Do you use any form of tobacco? _____ What Form? _____

Are you in good health? _____ If no, please explain _____

Date of last medical exam _____ Physician's Name _____

Are you currently under a physician's Care? _____ Physician's Phone#_____

Have you ever been hospitalized? _____ If so, why? _____

Do you have any other disease, problem or condition that you think I should know about?

_____

Are you sensitive or allergic to any drugs or medications? _____ Please List:

_____

Are you currently taking any drugs or medications? _____ Please List:

_____

For Women Only

Are you pregnant? _____ If so, when is your due date? _____

Physician's Name _____ Physicians Phone# _____

Physician's

Address:_____

Dental History

What is the main reason for your visit today? _____

How long since you have been to the dentist? _____

Have you ever been treated for periodontal disease? _____

Have you ever had any complications from routine dental treatment? _____

If so, please explain _____

Do you grind or clench your teeth? _____Do your gums bleed when you brush? _____

Do you have any sores, blisters, or swelling on your gums, lips or cheeks? _____

Have you ever had orthodontic treatment? _____

Are you happy with your smile? _____

Is there any additional medical or dental information we may need to know about you before beginning treatment?

_____

Consent

If signing for myself and/or a minor child, I hereby consent to the treatment indicated on the examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor. I, do hereby authorize the performance of dental services upon this patient and whatsoever procedures the judgment of the doctor may dictate in order to carry out treatment procedures as outlined in the treatment plan, I also authorize and request the administration of such anesthetics and/or sedatives as may be deemed advisable by the doctor. I understand if I am not present at time of service on my child, that I am authorizing the doctor to perform dental services deemed necessary at time of service.

I understand that my dental care insurance carrier or payer of my dental benefits may allow less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I agree to be responsible for all payments of services not paid in whole or in part, by my dental care payer. I also authorize dental insurance benefits to this office. I attest to the accuracy of the information on this page.

Patient Name: _____ Date: _____

Responsible Party Signature _____ Printed Name:_____

FINANCIAL AGREEMENT- PAYMENT IS REQUIRED FOR ALL DENTAL SERVICES AT THE TIME TREATMENT IS RENDERED. We accept Visa, MasterCard, Discover, American Express, Care Credit, Cash or Check.

INSURANCE FILING- THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYMENT IN FULL OF THEIR ACCOUNT, NOT THE INSURANCE COMPANY. We do, however, file dental insurance claims as a courtesy to our patients. We can **ONLY** make **ESTIMATES** regarding your insurance benefits based on the information provided by you and your insurance company. **In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.** Also, if we have not received payment from your insurance company within 60 days, YOU are responsible for paying the entire amount, and then to seek reimbursement from your insurance company. In the event that your account is ever over-paid, you will be given a credit on your account to be used for future dental care, or a refund will be issued.

In addition, your insurance may exclude or consider some services excludable. In the event this happens, you, the patient will be responsible for the total cost of the treatment. Not all insurance policies are identical, some have clauses which prevent your plan from covering standard dental procedures. Castle Valley Dental can not be held responsible for any clauses in your insurance policy. We strive to provide complete ESTIMATES to you, however, we may not have been informed by your insurance company of any specifics of the plan. If you are in doubt of what your plan covers, please request a pre-authorization of services.

ASSIGNMENT OF INSURANCE BENEFITS- I/We hereby assign directly to CASTLE VALLEY DENTAL, dental benefits otherwise payable to me/us. I/We hereby authorize the release of any information relating to any claims. I/We understand that I/We are financially responsible for charges not paid by this assignment.

RETURNED CHECKS OR NSF ACH DEBITS- In the event your check is returned unpaid due to insufficient funds, you authorize your check to be electronically redeposited for the face amount of the check. Recovery fees, as applicable by state law, will be assessed on all returned checks and **may** be collected from your checking account, and/or billed directly to you. By presenting your check for payment for your transaction, you are acknowledging your acceptance of our Check Acceptance Policy. In the event your account does not have the authorized funds to be debited you will be charged a minimum of $25 per NSF transaction. This fee applies to both checks and ACH Debits.

DELINQUENT ACCOUNTS- All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

COLLECTION PROCEEDINGS- In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fees for procedures at the time of service. If your account is turned over to collections, you and your family will be dismissed as patients.

CANCELLATION/TARDINESS- WE REQUIRE A 24 HR. NOTICE FOR ALL CANCELLED APPOINTMENTS. Individuals who fail to show for an appointment are subject to a cancellation fee of $50.00 per hour based on the length of the missed appointment time. We do understand that situations arise, (such as a sick child) and we are very sympathetic of those situations. A TARDINESS of more than 15 minutes for an appointment WILL be rescheduled, and may be subject to a missed appointment fee.

Patient Name: _____

Responsible Party Signature _____ Date: _____

CHANGES TO THIS FORM WILL NOT BE HONORED!

Office Policies Continued:

OUR OFFICE IS AN AMALGAM FREE OFFICE, which means we do not do any silver fillings. All of our fillings are done with resin material that is matched to the color of your teeth.

Most insurance companies will pay as though an amalgam filling was done because they are less expensive. For example, if the resin filling costs $100, the insurance company may pay for that same filling done as an amalgam (silver) filling which may be $80 they would then pay their percentage based on that lower fee. It is your responsibility as the patient to pay the difference. We do our best to estimate what your costs will be. We are always glad to answer any questions you may have.

ADULT SUPERVISION IS REQUIRED FOR ALL CHILDREN 13 and younger and all children who have medical conditions who are 17 and younger. Please check with the doctor or office staff regarding your child's health status with our office. If your child is left unattended, treatment will be stopped immediately and you will be charged for the cost of the appointment. If your child is over 14 years old and you must leave, you are required to provide a cell phone number and an additional emergency number. Please note; insurance does not allow us to bill them for treatment that was not completed due to patient non-compliance.

CELL PHONES MUST BE TURNED OFF while in the treatment areas. If we are unable to complete treatment due to cell phone use, you are still responsible for the cost of the appointment. Please note; insurance does not allow us to bill them for treatment that was not completed due to patient non-compliance.

PLEASE BE AWARE WE ARE ENFORCING MISSED APPOINTMENT FEES. If you do not call at least 24 hours in advance or you are more than 15 minutes late for your appointment we reserve the right to charge you a $50 missed appointment fee per hour of your appointment. This means if you were scheduled for a two hour appointment your fee would be $100. Most hygiene appointments are one hour, most crowns, fillings and scaling appointments are two hours. Please kindly give us 24 hours advance notice to change your appointment. This would include rescheduling or changing treatment. If requesting a change at the time of appointments due to time restrictions or cost, you may incur a missed appointment fee for the unused time you were scheduled. Please note; insurance does not allow us to bill them for treatment that was not completed due to patient non-compliance.

DUPLICATION FEE- There may be a $50 duplication fee per family to copy all x-rays.

WE RESERVE THE RIGHT to update our office policies at any time. As a patient you agree to abide by the policies set forth in our office.

I HAVE COMPLETELY READ AND UNDERSTAND THE CONTENTS OF THIS AGREEMENT. I AGREE TO COMPLY WITH ALL OFFICE POLICIES.

Patient Name: _____

Responsible Party Signature _____ Date: _____

Office Staff Signature _____ Date: _____

CHANGES TO THIS FORM WILL NOT BE HONORED!

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers (ie insurance, financing companies)
Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patients' signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____

Reason:_____

_____

_____

CHANGES TO THIS FORM WILL NOT BE HONORED!