PATIENT INFORMATION

Patient Name: _____ **Date:** _____/_____/_____
First MI Last

Gender: M / F **Married:** Yes / No **Date of Birth:** _____/_____/_____ **SSN:** _____

Patient Address: _____ **City, State, Zip:** _____

Home Tel: ( ) _____-_____ **Work:** ( ) _____-_____ ext _____ **Cell:** ( ) _____-_____

Email Address: _____ **Referred by:** _____

Physician – Name & Phone Number: _____ **Pharmacy Phone Number:** _____

Emergency Contact – Name & Phone Number : _____

Dental Insurance Carrier: _____ **Employer:** _____

HEALTH INFORMATION

If you have or ever had any of the following diseases, please check Yes or No the listed below.

☐ Yes ☐ No High Blood Pressure

☐ Yes ☐ No Low Blood Pressure

☐ Yes ☐ No Adverse effects from dental treatment

☐ Yes ☐ No Cardiovascular Disease: CIRCLE ONE
Heart Murmur, Stroke, Pace Maker, Angina, Coronary Artery Disease, Heart Attack, Heart Trouble, Palpitations, Mitral Valve Prolapse

☐ Yes ☐ No Lung Disease: CIRCLE ONE
Asthma, Emphysema, Bronchitis, Pneumonia, Tuberculosis, Chest Pain, Chronic Coughing

☐ Yes ☐ No CIRCLE ONE
Seizures, Convulsions, Epilepsy, Fainting; Dizziness, or Panic Disorder

☐ Yes ☐ No Bleeding Disorder, Anemia, Blood Transfusion

☐ Yes ☐ No Liver Disease : Jaundice, Hepatitis

☐ Yes ☐ No Artificial Joints / Implants

☐ Yes ☐ No Kidney Disease

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Thyroid Disease (Goiter)

☐ Yes ☐ No Arthritis

☐ Yes ☐ No Stomach Ulcers / Colitis

☐ Yes ☐ No Glaucoma

☐ Yes ☐ No Radiation Treatments for Cancer

☐ Yes ☐ No Sinus / Nasal Problems

☐ Yes ☐ No Clicking or Popping of Jaw Joint

☐ Yes ☐ No HIV / Hepatitis / Sexual Transmitted Diseases

☐ Yes ☐ No Recurrent infections of any kind

☐ Yes ☐ No Tumors

☐ Yes ☐ No Any reason for depressed immune system

☐ Yes ☐ No Nervous Disorder

☐ Yes ☐ No Mental Disorder

☐ Yes ☐ No Rheumatic Fever

☐ Yes ☐ No Other: _____

☐ Yes ☐ No Do you smoke or chew tobacco?

☐ Yes ☐ No Do you use alcohol?

☐ Yes ☐ No Are you using a controlled substance?

☐ Yes ☐ No Have you had any serious illnesses, operations, or hospitalizations?

Please describe: _____

FOR WOMEN ONLY

☐ Yes ☐ No Are you pregnant?

☐ Yes ☐ No Are you nursing?

☐ Yes ☐ No Are you using oral contraceptives?

☐ Yes ☐ No Are you using or taking any medications (including over the counter) medication?
If yes, please list: _____

☐ Yes ☐ No Are you allergic or have had a bad reaction to any medications?
If yes, please list: _____

Are you under a Physician's care for a particular reason? Y / N Date of last physical exam? _____

Please list any conditions or problems not listed above that you would like to speak with the doctor about: _____

_____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Patient /Guardian Signature: _____ Date _____

TIMBER CREEK DENTAL & Orthodontics

TO ALL OUR PATIENTS:

IN AN EFFORT TO KEEP DENTAL COST DOWN WHILE MANTAINING A HIGH LEVEL OF PROFESSIONAL CARE, WE HAVE ESTABLISHED THE FOLLOWING INFORMED CONSENT FOR OUR PATIENTS. WE ENCOURAGE OUR PATIENTS TO DISCUSS ANY QUESTIONS THEY MAY HAVE REGARDING OUR POLICES.

FINANCIAL POLICY:

(1) Payment is due in FULL at the time of visit.

(2) All appts that are MISSED or NOT CANCELED with a phone call within 24 hrs. of your scheduled appointment will incur a $50 missed appointment fee. Additionally, ALL MISSED or NOT CANCELED appointments on Dr. Casey's schedule will incur a missed appointment fee. $100 per hour, $50 for 30mins on his schedule. Please notify us as soon as possible if you need to cancel or reschedule your appointment.

(3) We accept Cash, Visa, Master Card, Discover, American Express cards, HSA cards and Care Credit.

If you have dental insurance, which provides coverage for this provider, we will be happy to help determine the coverage you have available.

(4) **Keep in mind, however, your insurance policy is a contract between you and your insurance company. We, therefore, cannot guarantee payment of your claims or accept responsibility for negotiating claims with insurance companies or another person.**

(5) If the insurance has not paid or denied your claim in 45 days, YOU ARE RESPONSIBLE for full payment of all unpaid claims.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SERVICE.

ALL FEES ARE SUBJECT TO CHANGE.

TIMBER CREEK
DENTAL
&
Orthodontics

I hereby authorize the release of any dental information necessary to process claims. I authorize the payment of benefits to the dentist described herein for services rendered.

STATEMENT OF UNDERSTANDING:

I have read and understand this information sheet and informed consent.

_____ _____

Patient or Guardian's Signature Date

TIMBER CREEK DENTAL & ORTHODONTICS

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Print name of Patient; _____ Date of birth; _____

We, at Timber Creek Dental, are required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information.

I hereby acknowledge that I have reviewed the HIPPA Notice of Privacy Practices document and understand that I may obtain a copy for my records upon request.

I, _____, authorize the release of my medical information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

Name:_____ Relationship:_____

Name: _____ Relationship:_____