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: ______________________

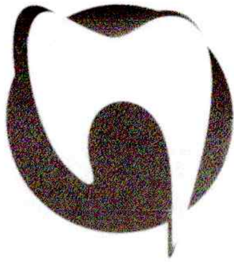
Are you under a Physician's care for a particular reason? Y / N Date of last physical exam? ______________

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** without a phone call within **24 hrs** of your scheduled appointment will incur a $50 missed appointment fee.

(3) Patients are responsible for making sure their XRAYS are sent over from their prior dental office or specialists office before they arrive for their appointment. If we have not received those XRAYS by the time of the appointment XRAYS will be taken for NEW PATIENTS, EMERGENCY EXAMS and other appointments if Dr. Casey deems it necessary to complete your exam.

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

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

(6) Keep in mind; however, your insurance policy is a contract between you and your insurance company. We, therefore, cannot guaranty payment of your claims or accept responsibility of negotiating claims with insurance companies or other person.

(7) 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 I FULL AT THE TIME OF EACH SERVICE.

ALL FEES ARE SUBJECT TO CHANGE.

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.

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers

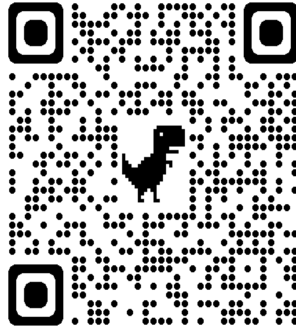
who may be involved in that treatment directly and indirectly.

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

I, ___________________________________, Name or specially identify the persons and/or organizations, which is authorization will allow to receive and use the protected health information described above. (Spouse, children, parent, etc. who is allowed to have access to this information.)

Name:________________________ Relationship:_________________________