# EAGLE CREEK DENTISTRY

**Welcome To Our Office!**

**PLEASE COMPLETE THESE THREE PAGES.**

Thank you for choosing Eagle Creek Dentistry as your dental care provider. We are committed to provide you the best possible dental care. If you have any problems or questions while completing the form below, we will be happy to help.

Chart #:_____
FOR OFFICE USE ONLY

## Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Driver's License #: _____ Expiration Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call:_____

Full Time Student? ☐ Yes ☐ No School Attending _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

**Emergency Information**: Please list the names and telephone numbers of two relatives (or friends) not living with you that we may contact in the case of an emergency.

Name _____ Relation _____ Name_____ Relation_____

Address _____ Address_____

Phone ( )_____ Phone ( )_____

## Insurance Information

**Primary Dental**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Effective Date: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Insurance Plan Phone Number: _____

## Insurance Information continued

**Secondary Dental**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Effective Date: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Insurance Plan Phone Number: _____

## FINANCIAL POLICY

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the dentist. Payment of services are due at the time services are rendered. We accept cash, check, credit cards and approved financing. **Please read and initial the following statements**.

**We may accept assignment of insurance benefits. However, you must understand that:

_____ 1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.

_____ 2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

_____ 3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

_____ 4. I understand that employees of Eagle Creek Dentistry are NOT representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company.

_____ 5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance does not pay, you are responsible for your payment.

_____ 6. **There will be a $25 fee charged for returned checks.**

_____ 7. **Balances older than 30 days may be subject to collection placement and a service charge of 1.5% per month.**

_____ 8. I authorize payment from my insurance carrier be made directly to the dentist.

_____ 9. I authorize this office to release necessary medical or dental information about me to my insurance carrier.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so we may assist you in management of your account. **If you need to cancel an appointment, please notify our office 24 hours in advance**. ***There will be a $25 charge for missed appointments, that were not cancelled in advance.***

****FIXED OR REMOVAL PROSTHETICS, such as dentures, crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services, is therefore, considered to be due and payable when the initial impression is made. We accept insurance for payment for the covered portion; however, you must pay your portion at the time services are rendered. PROSTHETICS, MUST BE SEATED IN A TIMELY MANNER TO INSURE YOUR COMFORT, AND PROPER FIT. If you fail to have your prosthetics permanently seated within 60 days from date of impression, a second impression must be made; you will be charged an additional amount. ALL X-RAYS TAKEN ARE A PART OF OUR PERMANENT RECORDS. **THERE IS A $10 DUPLICATION FEE FOR ANY X-RAYS REMOVED FROM THIS OFFICE. THERE IS A $5 DUPLICATION FEE, IF YOUR INSURANCE CARRIER REQUESTS X-RAYS FOR YOUR TREATMENT APPROVAL.**

In the event that this account should be placed for collection with an attorney or collection agency, the undersigned responsible party or parties agree to be both jointly and severably liable for any and all collection expenses. Collection expenses may include but are not limited to: collection agency fees, attorney fees, court costs, all litigation expenses and any other expenses or fees which may be incurred by Eagle Creek Dentistry, Dr. Singh, or their agents or assignees in collecting this account.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Again, thank you for choosing Eagle Creek Dentistry as your dental care provider. We appreciate your trust in us and the opportunity to serve you.

_____ Date: _____Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____Relationship to Patient: _____
Signature of guarantor of payment/Responsible party

## MEDICAL/DENTAL HISTORY

Date of Last Dental Visit: _____ Were x-rays taken at that time? ☐ Yes ☐ No
Were your teeth cleaned? ☐ Yes ☐ No
Reason for this visit:_____

**Have you ever had any of the following? Please check those that apply:**

☐ AIDS/HIV Positive
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy, convulsions or seizures
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney or Bladder Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis or Emphysema
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Blood Transfusion
☐ Shortness of Breath
☐ Swollen Ankles
☐ Cortisone-Steroid Treatment
☐ Chest Pains
☐ Artificial Heart Valve
☐ Mitral Valve Prolapse
☐ Thyroid Trouble
☐ Chemotherapy
☐ Radiation Therapy
☐ Psychiatric Treatment

**If You Are Female, Are You**
☐ **Pregnant**
Due date:_____
☐ Taking Birth Control Pills
☐ Taking Hormone Medication

OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you presently taking any drugs or medication? ☐ Yes ☐ No
  If yes, please list:_____
- Are you allergic to any medication, local anesthetic, materials or latex gloves? ☐ Yes ☐ No
  If yes, please list:_____
- Have you ever had a bleeding problem? ☐ Yes ☐ No
- Do you use tobacco products? ☐ Yes ☐ No
- Have you ever been treated for gum disease? ☐ Yes ☐ No
- Do you have bad breath? ☐ Yes ☐ No
- Do you clench or grind your teeth? ☐ Yes ☐ No
- Does your jaw click or pop? ☐ Yes ☐ No
- Have you experienced any pain or soreness in the muscles of your face or around your ear? ☐ Yes ☐ No
- Do you have any dental implants? ☐ Yes ☐ No
- Are you happy with your smile? ☐ Yes ☐ No
- Do you have any disease or condition not listed or anything about your health problem that we have not covered?

☐ Yes ☐ No If yes, please list_____

**RELEASE:**

**I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE.**

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I am responsible to inform the doctors at this office without fail.**

_____ Date:_____
Signature of patient, parent or guardian

## Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____