

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.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus / Nasal Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clicking or Popping of Jaw Joint |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Adverse effects from dental treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV / Hepatitis / Sexual Transmitted Diseases |
| | <u>Cardiovascular Disease: CIRCLE ONE</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recurrent infections of any kind |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur, Stroke, Pace Maker, Angina, Coronary Artery Disease, Heart Attack, Heart Trouble, Palpitations, Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors |
| | <u>Lung Disease: CIRCLE ONE</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any reason for depressed immune system |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma, Emphysema, Bronchitis, Pneumonia, Tuberculosis, Chest Pain, Chronic Coughing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Disorder |
| | <u>CIRCLE ONE</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Disorder |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures, Convulsions, Epilepsy, Fainting; Dizziness, or Panic Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Disorder, Anemia, Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease : Jaundice, Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you smoke or chew tobacco? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints / Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use alcohol? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you using a controlled substance? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you had any serious illnesses, operations, or hospitalizations? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease (Goiter) | | Please describe: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | FOR WOMEN ONLY | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers / Colitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you nursing? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments for Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> 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
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 HIPAA Notice of Privacy Practice 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: _____



TIMBER CREEK

— D E N T A L —
&
O r t h o d o n t i c s

TO ALL OUR PATIENTS

IN AN EFFORT TO KEEP DENTAL COST DOWN WHILE MAINTAINING 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 IN 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