Redrock Dental

www.redrockdds.com

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Acknowledgement of reciept of "Notice of Privacy Practices"
& Emergency Contact Information

* You may refuse to sign this acknowledgement*

I, ______________________________, have read, and or, was offered a copy of Redrock Dental's

"Notice of Privacy Practices"

I give permission for Redrock Dental to speak to the following regarding my dental treatment:

____

____

In an emergency situation, please notify the following:
(I allow the staff at Redrock Dental to deem what constitutes an emergency.)
Please note Name and Phone # of contact person

____

____

Signature ____ **Date** ________

Office Use Only
We attempted to obtain written acknowledgement of reciept of our "Notice of Privacy Practices" The acknowledgement could not be obtained because

__ The individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
Other: ____

____

Response Date: ___________

ALL OF THE FOLLOWING INFORMATION MUST COMPLETED ENTIRELY FOR PROPER ACCOUNT BILLING

Patient Information

Patient Name: ____ Date: __________
Last First MI

Preferred Name ______________________

Male ☐ Female ☐ Married ☐ Single ☐ Child ☐

Social Security # ____________________ Birth Date ______________________

Address: ____
Street Apartment #

____
City State Zip Code

Telephone Number (home) ( ) ________ (work) ( ) ____________ (other) ( ) ______________

E-Mail address: ____________________

Spouse or Responsible Party Information

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

Name: ____

Social Security # ______________ Birth Date ______________________

Telephone Number (home) (_____) ________ (work) (_____) ______________

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 Phone

Insurance Information

Name of Insured: ________________________ Occupation: ______________________

Insured Birth Date: _________ ID# or Soc Sec# ______________ Group # ______________

Insured Address: ____
Street City, State Zip Code Phone #

Insured Employer's Name: ____

Employer's Address: ____

Patient's relationship to insured: ____

Insurance Plan Name and Address: ____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, ☐Dental office, ☐Yellow Pages,

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

Emergency Contact: ____

Health History

Do you have a general physician? ☐Yes ☐No
Physician's Name:____
Phone # ____________
Are you taking any medication, prescription or non prescription? ☐Yes ☐No
If yes, list below. Please include vitamins, aspirin or other supplements.

____

____

Are you allergic to any medications or substances? ☐Yes ☐No
If yes, what?____
Do you have any other allergies? ☐Yes ☐No
Are you allergic to penicillin or antibiotics? ☐Yes ☐No
Are you sensitive to any metals or latex? ☐Yes ☐No
Have you ever received IV bone density medications? (ie.,Fosamax) ☐Yes ☐No
If female, do you use any birth control medications? ☐Yes ☐No
If female, are you or do you suspect that you may be pregnant? ☐Yes ☐No
Do you or have you had heart disease? Please circle all that apply. ☐Yes ☐No
Pacemaker Artificial Heart Valves History of infective endocarditis
Serious congenital (present from birth) heart conditions, including:
- unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
- a completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure
- any repaired congenital heart defect with residual defect at the site or adjacent to the site

A cardiac transplant that develops a problem in a heart valve.
Have you had a joint replacement within the last 2 years? ☐Yes ☐No
If yes, the date of your joint replacement _______________
Has any doctor ever told you that you should pre-medicate before dental treatment? ☐Yes ☐No
Do you have high or low blood pressure? ☐Yes ☐No
Have you ever had a serious illness, accident or major surgery? ☐Yes ☐No
If yes, explain: ____
Have you ever had radiation or chemo treatment for a condition? ☐Yes ☐No
Do you have any blood disorders? ☐Yes ☐No
Do you have a history of cold sores? ☐Yes ☐No
Do you bleed excessively after being cut or injured? ☐Yes ☐No
Do you have any stomach problems? ☐Yes ☐No
Do you have any kidney problems? ☐Yes ☐No
Do you have any liver problems? ☐Yes ☐No
Are you diabetic? ☐Yes ☐No
Do you have asthma? ☐Yes ☐No
Do you have epilepsy or seizures? ☐Yes ☐No
Do you have or have you tested positive for hepatitis? ☐Yes ☐No
Do you use tobacco products? ☐Yes ☐No
Do you have any disease, condition, or problem that is not listed? ☐Yes ☐No
If so, explain?____
Is there anything else we should know about your health? ☐Yes ☐No

Consent for Services

It will be helpful for you to know how the business aspects of our office are handled. To help you receive the best care, we ask that you spend a few minutes learning about our office policies.

Our office is opened to ages 3 and up for the practice of General Dentistry. When necessary, you will be referred to a specialist who will bill you directly.

Our business and clinical hours are normally, 7:30am to 4:00pm. We are open 4 days a week and alternate our days off, you may check with the front office for those days. For your convenience, we have Voice Mail to take your messages if we are unable to take your call.

ALL APPOINTMENTS ARE REQUIRED TO BE CONFIRMED. As a courtesy, we attempt to contact you for confirmation of the scheduled appointment. However, should contact not be made it is your responsibility to personally notify this office of your intentions in regard to a scheduled appointment. This will prevent the necessity of this office to reschedule the appointment. Our short notice cancellation/no show appointment policy is that we require 48-hour prior notice on all rescheduled and/or cancelled appointments. If the proper notice isn't given or you don't show for an appointment, a minimum fee of $50. will be accessed to your account. Three (3) such occurrences may result in your termination as a patient.

Late arrivals for a scheduled appointment are not always able to be seen by the provider due to courtesy to our other patients. A late arrival fee of $50 or portion of the treatment fee may be assessed. Repeated late arrivals may result in your termination as a patient.

Patients with dental insurance understand that all dental services furnished are charged directly to the patient and he/she is personally responsible for payment of all dental services. This office will help prepare patient's primary insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Your estimated portion is always due at the time that treatment is rendered.** I understand that the *estimate* listed is for this dental care can only be for a period of three months from the date of the patient examination.

Payment in full is expected at the time of the service. For crowns, dentures, partials, and prosthesis, your portion, not including estimated insurance payment, is due in full at the time impressions are taken.

To facilitate payment we accept Visa, Master Card, American Express, Discover, Carte Blanche, Diners Club, ATM, checks and cash. On approved credit, you may make financial arrangements through Care Credit. Applications are available at the front desk. Financial arrangement other than those stated above must be made prior to the appointment. Any balance over 60 days will be charged an annual interest rate of 23%, which is once every month. The policies are no reflection on your personal credit and we do appreciate your understanding and cooperation.

_______(initial) I authorize the release of my records and media currently in the possession and control of Redrock Family Dental for educational and/or information purposes. This media may include video, models and photographs. It is my understanding that my identity will not be used in conjunction with any this media.

In consideration for the professional service rendered to me, or at my request, by the Dentist, I agree to pay the value of said services to said Dentist, or the assignee, at the time said services are rendered. I further agree that the reasonable value of services shall be billed unless objected to, by me, in writing, within the time for payment thereof.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver term or condition and I further agree to pay costs and reasonable fees if suit were instituted hereafter.

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 agree to their content.

____________________________________Date:__________Relationship to Patient:________________________________
Signature of patient, parent or guardian

Dental Information

Purpose of initial visit? ____

Previous dentist name: ____

Location: ____

When was your last dental visit? _________________________________

( ) Yes ( ) No Were dental x-rays taken?

( ) Yes ( ) No May we request them to our office?

( ) Yes ( ) No Does food catch between your teeth every time you eat?

( ) Yes ( ) No Are any of your teeth sensitive? If yes, to what?___________

( ) Yes ( ) No Do your gums hurt or bleed?

( ) Yes ( ) No Are there any restorations (fillings or crowns) that you do not like?

( ) Yes ( ) No Do you like the appearance of your teeth?

( ) Yes ( ) No Are you interested in whitening your teeth?

( ) Yes ( ) No Do you feel that your breath is chronically offensive?

( ) Yes ( ) No Have you ever had gum surgery?

( ) Yes ( ) No Have you had orthodontic work (braces) done?

( ) Yes ( ) No Does dental treatment make you nervous?

( ) Yes ( ) No Have you ever had an unpleasant dental experience?

( ) Yes ( ) No Do you have any questions or concerns?

( ) Yes ( ) No Would you like to know about replacements for missing teeth?

( ) Yes ( ) No Have you had any problems with previous dental work?

( ) Yes ( ) No Do you clench or grind your teeth?

( ) Yes ( ) No Does your jaw click or pop?

Is there anything about dentistry that you strongly dislike? If yes, what?

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