PATIENT INFORMATION (1 of 3 pages)

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart # _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title _____ Gender: ◯ Male ◯ Female Family Status ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date _____

SS# _____ _____ _____

Prev. Visit _____

Email Address _____ Best Time to call _____

Phone: _____ _____ _____ _____
Home Mobile Work Ext. Fax Other

Address _____ _____
Address 1 Address 2

_____ _____
City State Zip Code

Emergency Contact Name _____ Phone _____

Who may we thank for the referral to our practice? _____

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____
Last First MI Preferred Name

Title _____ Spouse or Responsible Party SS#: _____ _____ _____

Birth Date _____

Email Address _____ Best Time to call _____

Phone: _____ _____ _____ _____
Home Mobile Work Ext. Fax Other

Address _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ Phone: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Primary Insurance Information

Name of Insured _____ _____ _____
Last First MI

Insured's Birth Date: _____

ID# _____ Group# _____

Insured's Address _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Secondary Insurance Information

Name of Insured _____ _____ _____
Last First MI

Insured's Birth Date: _____

ID# _____ Group# _____

Insured's Address _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

Address 1 Address 2

_____ _____ _____

City State Zip Code

Consent for Services

Signature of patient, parent, or guardian (responsible party):

Signature _____ Date _____

Relationship to Patient: _____

Response Date : _____

PATIENT HEALTH RECORD (1 of 4 pages)

Name _____

Date of Birth _____

Emergency Contact Name _____ **Phone** _____

General Health (please check):

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name and address of physician:

_____

_____

Last complete physical? _____

Are you currently being treated by a physician? ◯ Yes ◯ No

If so, what are you being treated for?

_____

_____

Are you currently taking any medications, prescription or herbal? ◯ Yes ◯ No

If yes, please list all medications, dose and frequency:

_____

_____

In the last five (5) years , have you been hospitalized? If so, please give reason and dates:

_____

_____

Is your blood pressure

◯ Normal ◯ Low ◯ High

Have you had any diagnostic x-rays taken in the last five years? ◯ Yes ◯ No

If so, what doctor's office and when?

_____

_____

Have you experienced any recent weight change? ◯ Yes ◯ No

If so, how long? _____

Have you ever had a blood transfusion? ◯ Yes ◯ No

Are you currently trying to modify your weight? ◯ Yes ◯ No

Are you taking any medications to help in weight modification? ◯ Yes ◯ No

Do you use nicotine products? (Tobacco, eCigarettes, gum, or patches) ◯ Yes ◯ No
If so, what, how much, and how often?

Do you consume alcohol on a daily basis? ◯ Yes ◯ No
If so, what, how much, and how often?

Do you have or have you ever been informed you had/have any of the following?

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Allergy - Benzapril
- ☐ Allergy - Keflex
- ☐ Arthritis
- ☐ Blood Thinner
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Heart valve replaced
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Tumors
- ☐ *Pre-Med - Clind
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Allergy - Demerol
- ☐ Allergy - Nickel
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ NOEPI
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Ulcers
- ☐ *Pre-Med - Other
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Allergy - Dilaudid
- ☐ Allergy - Pravastatin
- ☐ Asthma
- ☐ Cephalosporin
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Allergy - eggs
- ☐ Anemia
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sjogrens Syndrome
- ☐ Tumors

If you marked any of the above conditions listed, please explain:

Do you have or have you had any disease, condition, or problem not listed above? ◯ Yes ◯ No
If yes, please list:

Have you ever been tested for Hepatitis? ◯ Yes ◯ No
Do you have a history of cold sores, fever blisters, or canker sores? ◯ Yes ◯ No
Are you being treated with immuno-suppressive drugs? ◯ Yes ◯ No

Do you use well or city water?

◯ Well ◯ City

If well water, do you know the fluoride level? ◯ Yes ◯ No

When was your last dental visit? _____

Have you ever has any serious problems associated with dental treatment? ◯ Yes ◯ No

If yes, please explain:

_____

_____

How often do you brush your teeth? _____

How often do you floss? _____

Have you had previous treatment for periodontal disease?

If yes, explain:

_____

_____

Do you currently or have you used teeth whitening products? ◯ Yes ◯ No

Do you experience dry mouth (Xerostomia) or trouble swallowing? ◯ Yes ◯ No

Do your gums feel tender or swollen? ◯ Yes ◯ No

Do your gums bleed? ◯ Yes ◯ No

Do you avoid brushing any part of your mouth because of pain or sensitivity? ◯ Yes ◯ No

Are your teeth sensitive to hot/cold beverages or food or brushing? ◯ Yes ◯ No

If yes , where?

_____

_____

What texture brush do you use?

◯ Soft ◯ Medium ◯ Hard

Do you chew on only one side of your mouth? ◯ Yes ◯ No

Are there areas where food gets stuck between your teeth? ◯ Yes ◯ No

Do you feel like your teeth are affecting your health in any way?

_____

_____

Do you clench or grind your teeth while sleeping or awake? ◯ Yes ◯ No

Do you wear a bite guard? ◯ Yes ◯ No

Do your facial muscles ever feel tired? ◯ Yes ◯ No

Do you gag easily? ◯ Yes ◯ No

Are you nervous or apprehensive about dental treatment? ◯ Yes ◯ No

If yes, have you had:

◯ Nitrous Oxide (Laughing Gas) ◯ Medication prior to treatment

Please list anything else you feel is important:

_____

_____

Consent

The undersigned hereby authorize the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications , and the use of local anesthetic agents.

Signature _____ Date _____

Doctor Signature and date

Signature _____ Date _____

Response Date : _____

Consent for Internet Communications

I grant my permission to Copper Ridge Dental to upload and store confidential information (including account information, appointment information and clinical information) to the secured website for the dental practice. I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Copper Ridge Dental will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Copper Ridge Dental, has the right to monitor, retrieve, store, upload, and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information . I understand Copper Ridge Dental will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand Copper Ridge Dental CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I also grant permission to transmit my patient information on my behalf to other health care providers on a referral basis for the continuance of care.

☐ *By checking this box, I acknowledge that I have read this statement and agree to the contents.

Truth In Lending Statement & Financial Summary

We are committed to providing you with the best possible professional care. This care can be furnished only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our billing or financial policies with our staff.

As a condition of your treatment by this office, financial arrangements must be made in advance. The Practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, within five (5) days of billing if credit is extended, or within five (5) days of billing if billing insurance companies comes first. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Insurance
We participate with Delta Dental and Cigna. Participation means that we will submit claims on your behalf and accept assignment of benefits on covered services. You are responsible for applicable co-pay and deductible amounts at the time of service.

For patients with insurance we do not participate with, (payment is also required at the time of service) for all procedures. We will submit a claim to your insurance carrier on you behalf. Please understand any amounts not paid by your insurance company are your responsibility.

Credit Cards
For your convenience, we do accept VISA, MasterCard, Discover, and American Express credit cards.

Financing Plan
We offer financing through Care Credit. Please ask an office team member if you would like more information or an application.

Cancellation Policy
If you are unable to keep you appointment , please call the office 24 hours in advance. If you fail to come to a scheduled appointment, for either the doctor or the hygienist, please be aware that your account will be charged a nominal fee of $25. This will not be billed to your insurance, but to your personal account. Please keep in mind that your insurance is a contract between you, your employer, and the insurance company itself. Our fees are considered usual, customary and reasonable (UCR) by most companies. Some insurance companies arbitrarily select certain services that they will not cover. We must emphasize that our relationship is with you, not your insurance company . While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. If your insurance has not been paid within 60 days from the date your services are rendered it becomes your responsibility to pay this balance . Should we receive payment from your insurance, we will reimburse you. We attempt lo keep informed and up lo dale on your benefits, but if/when your benefits change we need to be notified by you of that change. Unfortunately, we are not notified by your insurance company. It is your responsibility to keep track of benefit levels and coverage . If you have any questions about the above information, please do not hesitate to ask. We are here to assist you.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

☐ *By checking this box, I acknowledge that I have read this statement and agree to the contents.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
Consent for use and disclosure for Treatment, Payment & Healthcare Operation
Right to Restrict and/or Revoke Authorization

Section A: Consent for Treatment, Payment and Health Care Operations

I hereby consent for the use or disclosure of my individually identifiable health information to carry out treatment, payment or health care operations. This includes assignment of benefits.

This consent is authorized for the following:
Family Physician, Family Hospital, Other Dental Specialist, Insurance Company, Immediate Family Members. If you wish to deny consent to any of these providers/individuals, please list under restrictions. Please list any additional providers/individuals you wish to include:

_____

_____

If you wish to deny consent to any of these providers / individuals, please list below. (Note, denials are subject to approval by the office for normal and customary course of business)

_____

_____

☐ *By Checking this box, I acknowledge that I have read this statement and agree to the contents.

Response Date: _____