PATIENT INFORMATION

Date _____ Home Phone _____ E-Mail Address _____ Work Phone _____

PERSONAL INFORMATION	SPOUSE / PARENT INFORMATION
Name_____ Address_____ City_____ Zip_____ Birth Date_____ Age_____ Employer_____ Business Address_____ City_____ Zip_____ Position_____ Social Security #_____	Name_____ Employer_____ Business Address_____ City_____ Zip_____ Business Phone_____ Position_____ Social Security #_____ Birth Date_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

GENERAL INFORMATION	
Convenient appointment time_____ Are you available for appointments on short notice?____ Person to contact for emergency_____ Relationship to patient_____ Their telephone_____	Person responsible for account_____ Address_____ Relationship to patient_____ Employer_____ Driver's License #_____ Social Security #_____

If you have dental insurance, please fill in the following:

PRIMARY CARRIER	SECONDARY CARRIER
Name of Insured_____ Birth Date of Insured_____ Social Security #_____ Insurance carrier name_____ Employer_____ Union or Local #_____ AID or Group #_____ Date Employed_____ Insurance carrier address_____	Name of Insured_____ Birth Date of Insured_____ Social Security #_____ Insurance carrier name_____ Employer_____ Union or Local #_____ AID or Group #_____ Date Employed_____ Insurance carrier address_____

Spring Creek Dental
WE MAKE YOU SMILE

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

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

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 18% per month* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided By the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, parent or guardian **Date**

Relationship to Patient _____

(Rov.4/10)

*The interest rate charged may be at the discretion of your office or accountant.

Spring Creek Dental
WE MAKE YOU SMILE

Medical and Dental History

PATIENT NAME:_____ DATE OF BIRTH:_____
PHYSICIAN'S NAME:_____ PHONE:_____

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

1. Do you consider yourself to be in good health? ----------□Yes □No
2. Are you now or have you ever been under a physician's care within the past year?----------□Yes □No
   If Yes, specify condition being treated:_____
3. Do you have or have ever had any heart or blood problems?----------□Yes □No
4. Have you ever been told you have a heart murmur?----------□Yes □No
5. Do you have or have you ever had high blood pressure?----------□Yes □No
6. Do you bleed or bruise easily?----------□Yes □No
7. Are you subject to fainting?----------□Yes □No
8. Have you ever been diagnosed as being HIV positive or having AIDS?----------□Yes □No
9. Have you ever had hepatitis or liver disease?----------□Yes □No
10. Have you ever had (check all that apply); asthma_____; any blood disorder_____; kidney disease_____; diabetes_____; joint pain/arthritis_____; tuberculosis_____; pneumonia_____; heart attack or endocarditis_____; rheumatic fever_____; immune system disorders____; other significant disease____ (if yes please specify_____)
11. Do you take any medications, including birth control pills?----------□Yes □No
    Please specify name and purpose of medications:_____
    _____
    _____
12. Have you ever had an unusual reaction or are you allergic to any of the following drugs:----------□Yes □No
    Penicillin_____; Aspirin_____; Acetaminophen_____; Ibuprofen_____; Codeine_____; Barbiturates_____; Sulfa Drugs_____; Other_____
13. Do you require antibiotic pre-medication for a heart condition or artificial valve, etc.?----------□Yes □No
14. Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?----------□Yes □No
15. Have you ever used or are you now using tobacco products?----------□Yes □No
    If yes please describe the use history:_____
16. Is there any family history of substance abuse or misuse?----------□Yes □No
17. Is there any personal history of substance abuse or misuse?----------□Yes □No
18. Have you ever received counseling for use of alcohol and/or prescription drugs?----------□Yes □No
19. Do you take any sedative medication including herbal supplements?----------□Yes □No
20. Do you have any other allergies? If Yes, please describe:_____ □Yes □No
21. Have you ever had a nervous breakdown or undergone psychiatric treatment?----------□Yes □No
22. Women: Are you pregnant?----------□Yes □No
23. Are you now in pain?----------□Yes □No
24. How long ago did you last see a dentist?_____
25. If you are new to our office, who was your previous dentist?_____
26. Do you think your teeth are affecting your general health in any way?----------□Yes □No
27. Have you ever had any severe reaction to dental treatment or local anesthetics?----------□Yes □No
28. Are you allergic to any local anesthetic?----------□Yes □No
29. Do you have or have you ever had bleeding or sensitive gums?----------□Yes □No
    If yes, have you seen your physician or cardiologist for a cardiac evaluation? _____

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR MEDICATIONS I TAKE, CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature_____ Date_____
(Patient, legal guardian or authorized agent of patient)

CONSENT TO PROCEED

I authorize Dr. McNaughtan and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. I understand that the removal of deep decay may lead to complications including but not limited to pulpal necrosis, infection, loss of significant tooth structure, and other problems. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:

Signature:_____**Date:**_____

(Patient, legal guardian or authorized agent of patient)

Witness:_____ **Date:**_____

(Rev 7/08)