Rolling Valley Dental
Patient Information

Thank you for selecting our dental healthcare team! We at Rolling Valley Dental always strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions, please ask us. We will be happy to help!

Personal Information (Confidential)

Today's Date: ____ / ____ / _________ SSN: _______ - ______ - __________ Primary Phone: ______________

Name: _____________________________________ Date of Birth: ____ / ____ / ____

Home Address: ______________________________________ City: ______________ State: ____ Zip: ________

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated (*Check Appropriate Box*)

If a Student, Name of School: ____________________________________ City: ___________________ State: ____

Emergency Contact: ____ Home Phone: ______________

Spouse/Parent's Name: ____ Home Phone: ______________

Patient's/Parent's Employer: ____ Work Phone: ______________

Business Address: _____________________________________ City: _______________ State: ____ Zip: ________

Who Referred You to Us: ____

Person Responsible for this Account: ____

Relationship to Patient: _______________ Home Phone: ______________ Email: __________________________

Home Address: ______________________________________ City: ______________ State: ____ Zip:________

Insurance Information

Name of Insured: _____________________________________ Relationship to Patient: _______________

Date of Birth: ____ / ____ / ____ SSN: _______ - ______ - __________ Date Employed: ____ / ____ / ____

Name of Employer: ____ Work Phone: ______________

Insurance Company: _______________________________ Group #:______________ Member ID #:____________

Address: ____ City: _______________ State: ____ Zip: ________

Deductible: $____________ Deductible Already Used: $____________ Maximum Annual Benefits: $____________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can compromise my health. I authorize Rolling Valley Dental to release information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay insurance benefits, otherwise payable to me, directly to Rolling Valley Dental. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Furthermore, I agree that in the event of nonpayment, I will bear the cost of additional attorney fees and court costs.

____ ____ / ____ / ____

Signature of Patient (or Parent, if a minor) Date Employed Date

Patient Medical & Dental Information

Name: ____________________________________ Age: _____ Date: ____ / ____ / _________

Medical History

- ☐ Y ☐ N Are you under any Medical treatment now?
- ☐ Y ☐ N Have you had any major operations? If "Yes", what? ________________________________
- ☐ Y ☐ N Have you ever had a serious accident involving head or jaw injuries?
- ☐ Y ☐ N Have you ever had any adverse response to any drugs, including penicillin and aspirin?
- ☐ Y ☐ N Have you ever had any of the following?
  - ☐ Heart Ailment ☐ Any Blood Disease ☐ Any Liver Disease ☐ Diabetes
  - ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Any Kidney Disease ☐ Epilepsy
  - ☐ Respiratory Disease ☐ Any Venereal Disease ☐ Rheumatic Fever ☐ Yellow Jaundice/Hepatitis
  - ☐ Rheumatism or Arthritis ☐ Tumors or Growths ☐ AIDS ☐ Any Stomach or Intestinal Disease
- ☐ Y ☐ N Are you on a diet at this time?
- ☐ Y ☐ N Are you pregnant?
- ☐ Y ☐ N Are you now taking drugs or medications? If so, please fill out the table below.
- ☐ Y ☐ N Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?
- ☐ Y ☐ N Do you have any reason to suspect you are not in good health today?
- ☐ Y ☐ N Have any wounds healed slowly or presented other complications?
- ☐ Y ☐ N Do you have a history of fainting?
- ☐ Y ☐ N Ever had any X-Ray treatments (other than diagnostic)?
- ☐ Y ☐ N Have you ever received any donor organs/artificial heart valve/vessels/joint implants/pacemaker?
- ☐ Y ☐ N Do you have a persistent cough/throat clearing not associated with a known illness (lasting more than 3 weeks)?
- ☐ Y ☐ N Have you ever taken Fen-Phen/Redux?
- ☐ Y ☐ N Do you have a history of Tuberculosis?

Dental History

- ☐ Y ☐ N Do you have any specific problems?
- ☐ Y ☐ N Do you have any unhealed injuries, or inflamed areas in or around your mouth?
- ☐ Y ☐ N Have you experienced any growth or sore spots in your mouth?
- ☐ Y ☐ N Does any part of your mouth hurt when clenched?
- ☐ Y ☐ N Do your gums bleed?
- ☐ Y ☐ N Do you have pain in or near your ears?
- ☐ Y ☐ N Do you chew on only one side of your mouth?
- ☐ Y ☐ N Have you ever had Novocain anesthetic?
- ☐ Y ☐ N Any reactions or allergic symptoms to Novocain?
- ☐ Y ☐ N Any difficult extractions in the past?
- ☐ Y ☐ N In the past, have you had prolonged bleeding following extractions?
- ☐ Y ☐ N Have you ever been instructed on the correct method of brushing your teeth?
- ☐ Y ☐ N Have you ever been instructed on the care of your gums?
- ☐ Y ☐ N Do you habitually clench your teeth during the day or night?
- ☐ Y ☐ N Is any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? Locate: ______________________

When was your last full-mouth X-Ray taken? __________________. Locate: ______________________

Medications

Current Medication	Reason for Taking	Current Medication	Reason for Taking

Certification

I certify that the answers given in filling out this form are correct to the best of my knowledge.

____ ____ / ____ / ____

Signature of Patient (or Parent, if a minor) Date Employed Date

Financial Agreement

____

Patient's Name (last name, first name)

We at Rolling Valley Dental believe that all patients deserve the very best dental care, and appreciate this opportunity to serve you. It is very important that the cost of treatment not prevent you from benefitting from the quality of care you desire and deserve. In support of this, we believe that a clear understanding of our financial policy prior to dental care helps relieve some of the anxiety associated with dental visits. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

Our financial terms and conditions are listed, below. Please read this information carefully before signing and dating this Financial Agreement:

- For Patients *without* Insurance Coverage
  The fee for the balance on your statement must be paid in full on the day of service, unless we have approved other arrangements in writing.

- For Patients *with* Insurance Coverage
  a. The estimated patient co-pay and deductible for the treatment rendered must be paid in full on the day of service.
  b. If a payment from your insurance is not received within four weeks, then you are responsible for paying the remaining balance and contacting your insurance company for reimbursement. You are ultimately responsible for any portion of your bill not covered by your insurance provider.

- We accept Visa, MasterCard, personal checks, and cash
  Payment plans are available upon request. If a check provided by you to the practice in payment for services delivered is returned due to insufficient funds, a $50.00 returned check fee will be added to the amount due, and we will no longer accept personal checks from that account holder.

- Refunds
  Refunds for overpayment will be sent to you after all treatment is completed, and insurance has been collected.

- Two Business-Days Notice are Required for Rescheduling/Canceling Appointments
  Each patient is of equal importance to us, and we do our best to accommodate everyone's schedule. If you need to cancel or reschedule your appointment, please contact us at least two business days prior to that scheduled appointment.

  If a scheduled appointment is not rescheduled or canceled at least two business days prior to the date/time of the original appointment, a fee of $25.00 will be charged to the patient's account. *Note: Emergencies will be taken into consideration.*

The Financial Agreement continues on the next page of this form. ⇨⇨⇨

- <u>No Show Appointments</u>
  If a scheduled appointment is not canceled at least two business days prior to the date/time of that appointment, a fee of $50.00 will be charged to patients account. *Note: Emergencies will be taken into consideration.*

- <u>After Hours Emergency Visits</u>
  We make every effort to provide emergency support to all patients in distress. If we schedule an appointment outside of normal business hours, a fee of $50.00 will be added to the cost of that service.

Concurrence with This Financial Agreement

I understand that I am financially responsible for the entire amount of my dental services. Unless other financial arrangements have been made, payment in full is due at the time of service. When applicable, I will file a claim with my insurance company. I hereby assign my payable insurance benefits to Rolling Valley Dental, which will be applied to my bill. I am responsible for paying any remaining balance not covered by my insurance. I authorize the release of any necessary information necessary to process my insurance claim.

____
Name of Patient (Please Print)

____
Name of Responsible Party, if Different from Patient (Please Print)

____ ____ / ___ / _________
Signature of Patient/Responsible Party Date