**Patient Information**

PATIENT'S NAME _____ Birth Date _____
First MI Last

Married ☐ Single ☐ Minor ☐ Male ☐ Female ☐

Address _____ City/State/Zip _____

Telephone (home) _____ (work) _____ (cell) _____

SS# _____ Email address _____

Employer _____ Occupation _____

**Initial here if the responsible party is the same as above_____**

**Responsible Party Information**

NAME _____ Birth Date _____
First MI Last

Address _____
Street City State Zip

Telephone (home) _____ (work) _____ (cell) _____

Employer _____ Occupation _____

Relationship to Patient _____ Social Security # _____

**Responsible Party's Spouse**

NAME _____ Birth Date _____
First MI Last

Address (if different from above) _____
Street City State Zip

Telephone (home) _____ (work) _____ (cell) _____

Employer _____ Occupation _____

**Emergency Contact (Relative not living with you)**

Name: _____ Relationship _____

Address: _____ Phone _____
Street City State Zip

Whom may we thank for referring you to our office? _____

Method of Payment (Please check one)

Payment in full at each appointment for my estimated portions. (cash, check, Visa, Master Card, American Express, or Discover).

I would like to hear about your finance options through Care Credit.

I certify that this information is true. I will notify you of any changes. I understand there is a **$50 per hour fee** for a missed or canceled appointment without a notice of **2 business days**.

Print patient name _____

Signed _____ Date _____

# Financial Policies

**Copper Ridge Dental** accepts several forms of payment for dental treatment provided at this office: ***Cash, debit card, personal check, credit card*** (MasterCard, Visa, Discover, American Express).

***Financing Options***: We offer convenient monthly payment plans through Care Credit. This third party financial group offers six and twelve month payment plans with no interest. The application is simple and can be completed online, over the phone, or in the office.

***Dental Insurance***: Understanding your insurance coverage can be quite a challenge. Our goal is to provide reasonable assistance to help you maximize your benefits. Most dental insurance excludes coverage for some services, uses restricted fee schedules for most services, and can decline payment based on any number of policy restrictions and limitations. All such restrictions and limitations are based on the premium paid by your employer for the coverage, *not* on our fees or the treatment we recommend. We encourage you to become familiar with your policy: its coverage, exclusions, deductibles and maximums. ***We will recommend treatment appropriate to your dental needs regardless of your insurance coverage***.

***Our courtesy service to our insured patients includes:***

1) Filing your claims promptly and requesting that payment be sent directly to us.
2) Following American Dental Association guidelines for claims coding and filing.
3) Estimating your benefits to the best of our ability. Most insurance companies will *not* provide us with detailed information about your coverage, so any insurance figures we provide you are only estimates!

***Our expectations of you as the insured patient and/or owner of the policy:***

1) You will pay, at the time of service, your fees estimated not to be covered by your insurance (co-payment).
2) You will assume responsibility for any amounts expected from your insurance company but not received within 60 days after treatment has been performed and the claim submitted. Please understand that the insurance policy belongs to ***you*** and we have no leverage to obtain payment from your insurance company.

I hereby authorize Copper Ridge Dental to release to my insurance company any information acquired in the course of my dental care. I authorize benefits to be paid directly to Dr. Erik Cantwell. I understand I am responsible for all fees incurred, **regardless of insurance involvement**. I understand that treatment cannot be completed until it is paid for (e.g., crowns will not be cemented, dentures will not be placed). 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 understand that interest charges of 1.5% per month (18% annually) will accrue on balances older than 60 days. 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.

The following family members are covered by this agreement:

_____

Responsible Party: _____

_____ _____

Signature Date

## HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

**I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.**

I authorize Dr. Erik Cantwell, 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, temporary or, rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of 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. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

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.

Signature:_____ Date:_____

Witness: _____ Date _____

# INSURANCE

## IT IS YOUR RESPONSIBILITY TO KNOW HOW IT WORKS

As a courtesy we will submit your insurance claim for you. If we file your insurance claim and they deny payment due to waiting periods, frequencies, or plan limitations, payment is due from **you**. In an effort to COLLECT payment from your insurance we need all information to be current and accurate.

Please inform us of any changes with your insurance as soon as you are aware of them.

We will estimate your co pay to the best of our ability. This will be due at the time of service. Remember, this is just an estimate. Any balance unpaid is your responsibility.

## PRIMARY INSURANCE

POLICY HOLDER _____

EMPLOYER _____

SOCIAL OR I.D.# _____

**PRIMARY INSURANCE COMPANY** _____

CLAIMS
ADDRESS _____

PHONE # _____

## SECONDARY INSURANCE

Ideally, having two insurance carriers leaves the patient with little or no out of pocket expense. However, some insurance companies do coordinate benefits.

If your secondary insurance denies or fails to pay a claim, your payment is due immediately.

POLICY HOLDER _____

EMPLOYER _____

SOCIAL OR I.D.# _____

**SECONDARY INSURANCE COMPANY** _____

CLAIMS
ADDRESS _____

PHONE # _____

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 reviewed Copper Ridge Dental's policy concerning insurance.

Print Patient Name: _____

Signature: _____ Date: _____

PATIENT NAME: _____ DATE: _____

**Medical History** *Please Circle*

Have you been under the care of a medical doctor or had a hospital visit during the past two years? ..... YES NO
If yes, list the condition(s) being treated: _____
Have you taken any medicine or drugs during the past two years? ..... YES NO
If yes, list them: _____
Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications, or contact to metals? ..... YES NO
If yes, list them: _____
Have you ever had any excessive bleeding requiring special treatment? ..... YES NO
Do you smoke or use tobacco in any form? ..... YES NO
Are you presently taking Coumadin, Heparin, or any other blood thinner? ..... YES NO

Do you now have, or have you ever had any of the following? Please check YES or NO.

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Heart Failure/Heart Attack | ☐ | ☐ | Hepatitis A (infectious) | ☐ | ☐ | Asthma |
| ☐ | ☐ | Heart Disease | ☐ | ☐ | Hepatitis B or C (serum) | ☐ | ☐ | Hay Fever |
| ☐ | ☐ | Angina Pectoris/Chest Pain | ☐ | ☐ | Liver Disease | ☐ | ☐ | Sinus Trouble |
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | Yellow Jaundice | ☐ | ☐ | Allergy or Hives |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Drug Addiction | ☐ | ☐ | Thyroid Disease |
| ☐ | ☐ | Congenital Heart Lesions | ☐ | ☐ | Anemia | ☐ | ☐ | Arthritis/Rheumatism |
| ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Hemophilia | ☐ | ☐ | Cortisone Medicine |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Sickle Cell Disease | ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Scarlet Fever | ☐ | ☐ | Bruise Easily | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Heart Pacemaker | ☐ | ☐ | Venereal Disease | ☐ | ☐ | Hypoglycemia |
| ☐ | ☐ | Heart Surgery | ☐ | ☐ | Cold Sores | ☐ | ☐ | Ulcers |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Genital Herpes | ☐ | ☐ | Stomach/Intestinal Disease |
| ☐ | ☐ | Artificial Joint (Knee, Hip,etc.) | ☐ | ☐ | Epilepsy or Seizures | ☐ | ☐ | Chemotherapy (Cancer, |
| ☐ | ☐ | Stroke | ☐ | ☐ | Fainting or Dizzy Spells | | | Leukemia) |
| ☐ | ☐ | Kidney Trouble | ☐ | ☐ | Chronic Cough | ☐ | ☐ | X-ray or Cobalt Treatment |
| ☐ | ☐ | AIDS | ☐ | ☐ | Tuberculosis (TB) | ☐ | ☐ | Nervousness |
| ☐ | ☐ | HIV Positive | ☐ | ☐ | Emphysema | ☐ | ☐ | Psychiatric Treatment |
| ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Lung Disease | ☐ | ☐ | Eating Disorder |

Have you received I.V. bisphosphonate therapy (Zometa, Aredia, Boniva) or are you taking oral bisphosphonates (Fosamax, Actonel, Skelid)? ..... YES NO
When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
Do you ever wake up from sleep short of breath? ..... YES NO
Do you have any difficulty breathing? ..... YES NO
Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
Have you been diagnosed with human papillomavirus (HPV)? ..... YES NO
Do you have any disease, condition, or problem not listed? ..... YES NO
If yes, list: _____

**Women**:

Are you pregnant or nursing currently? ..... YES NO
Are you taking birth control pills? ..... YES NO
Do you anticipate becoming pregnant? ..... YES NO

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, **I understand the importance of and agree to notify the dentist of any change in this health information or medications at any subsequent appointment.**

X_____ Date _____
SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN

Reviewed by Doctor/Hygienist _____ Date _____

COPPER RIDGE
DENTAL

## PLEASE INDICATE WHETHER OR NOT YOU WOULD LIKE FLUORIDE TREATMENT

Dr. Cantwell recommends fluoride treatment every 6 months for your benefit, however, in recent years dental coding has been changed. The code for a cleaning no longer includes fluoride treatment. It is now treated as a separate code. We are finding that there are age and frequency limitations for fluoride coverage based on your dental plan. Although we would like to, we cannot know the limitations of every insurance policy. It is your responsibility to know these limitations.

☐ (Yes, I would like fluoride)
At a cost of $26.00 out of pocket, I would like fluoride as part of my appointment today. If my insurance does cover it, I understand that this will be credited to my account.

☐ (No, I do not want fluoride at this time )
At this time, I have been advised of the benefits of fluoride but do not wish to have it as part of my treatment today.

Patient name: _____ Date: _____

Signature :_____

**Dr. Erik Cantwell**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have reviewed a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature (Patient, Parent or Guardian)

_____
Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____