Spring Valley
Dental Group

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss** ☐ **Dr.**	**Patient Name:**	
Social Security Number:	**Date of Birth:**	☐ **Child** ☐ **Single** ☐ **Married** ☐ **Other**
Address:		
City:	**State:**	**Zip:**
Home Phone: ( )	**Work Phone: ( )**	**Cell Phone: ( )**
Email:	**Preferred Method of Contact:** ☐ **Phone** ☐ **Email**	
Patient Employer or School:	**Occupation:**	
Emergency Contact:	**Relationship:**	**Phone: ( )**
How did you hear about us? ☐ **Website / Online** ☐ **Sign / Drove by** ☐ **Other:** ☐ **Friend or Family Member:**		
Responsible Party and/or Primary Insurance Information: (Please notify us if there is secondary dental coverage)		
Relationship to Patient: ☐ **Self** (if self, skip to insurance info) ☐ **Spouse** ☐ **Parent** ☐ **Other:**		
Responsible Party's Name or Policy Holder's Name:		
Date of Birth:	**Social Security Number:**	☐ **Single** ☐ **Married** ☐ **Other**
Address:		
City:	**State:**	**Zip:**
Home Phone: ( )	**Work Phone: ( )**	**Cell Phone: ( )**
Employer:	**Occupation:**	
Insurance Plan Name:	**Insurance Group Number:**	
Insurance Plan Phone Number: ( )	**Insurance Subscriber ID Number:**	

Payment Options

- Cash, Credit, Debit, Check (with a valid Driver's License) and Care Credit. Balances are due at the time of service.
- Care Credit: 6 and 12month interest free payment plans for those who qualify. Also, extended payment plans available with a low interest rate charged to patient. We will be glad to help you with the application!

Payment Policies

- Fees are determined by the services required. Please let your doctor's receptionist know if you have any questions in regards to this.
- If you are insured: your estimated co-payment is due at the time of service. We will submit your claim as a courtesy to you, however; you are responsible for any remaining balance after your insurance makes their payment.

Collections Policy

- If a collection agency is used to recover any unpaid balance due to us, the responsible party is liable for all charged occurred. You will be charged $25.00 for a returned check with insufficient funds. $10.00 for each time a check is reprocessed. Any patient that has a returned check will be placed on a cash, credit, or debit only payment status.

Appointment Cancellation Policy

- Failure to give our office 24 hour notice and/or arriving 15 minutes late for your appointment may result in a charge of $75.00/per hour of scheduled time. Please provide ample notification if you need to change your appointment. Your appointment has been reserved exclusively for you and if you are unable to attend, your appointment time may be appreciated by another patient. Please respect our time and the patients scheduled after you. You will be dismissed as a patient if you are consistently missing or arriving late for appointments.

Signature of Patient, Parent or Guardian: **Date:**

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Patient's Name:	**Date of Birth:**
If Minor – Parent's Name:	

DENTAL HISTORY

Have you been having any specific problems? ☐ Yes ☐ No
Describe:

Last Dental visit:	**Purpose:**	**Last Complete Exam:**
Previous Dentist's Name:		**Phone Number: ( )**

Has fear or discomfort kept you from regular visits? ☐ Yes ☐ No

Is your dental health: ☐ Good ☐ Fair ☐ Poor	**Do you feel decay?** ☐ Yes ☐ No	**Gum Disease?** ☐ Yes ☐ No

How often do you brush your teeth?	**How often do you floss?**

What other dental aids do you use (electric toothbrush, waterpik, etc.)? :

How do you feel about your smile? ☐ Good ☐ Fair ☐ Poor

Is there anything you'd like to change about your smile?

Are you interested in whitening your teeth? ☐ Yes ☐ No	**Are you interested in straightening your teeth?** ☐ **Yes** ☐ **No**

Would you be interested in a Juvéderm or Botox treatment? ☐ Yes ☐ No

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No
If yes, please describe why:

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No
If yes, please describe:

MEDICAL HISTORY

Name of your Physician: (if you do not have a physician, please write none.)

Last Exam:	**Phone Number: ( )**

Women: Are you pregnant or think you could be pregnant? ☐ Yes ☐ No **Expected Delivery Date:**

Are you taking birth control? ☐ Yes ☐ No **Nursing?** ☐ Yes ☐ No

Are you under a doctor's care now? ☐ Yes ☐ No
If so, for what reason?

Current use of any tobacco products? ☐ None ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing tobacco ☐ Other

Because of anesthetic, we need to know if you currently or have used any street/illicit drugs. If so, please list:

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Are you taking any pills, medication or prescription drugs? ☐ Yes ☐ No

Please List:

Do you have or have you ever been treated for any of the following? Please check all that apply.

☐ AIDS/HIV
☐ Acid Reflux / GERD
☐ Allergy to ☐ Medications
☐ Anesthetic ☐ Seasonal allergies
List:

☐ Angina / Chest pain
☐ Anti-depression treatment
☐ Arthritis / Rheumatism
Type:

☐ Artificial heart valves
Date:

☐ Artificial joints
Date:

☐ Aspirin treatment / Blood thinner
☐ Asthma / Inhaler
☐ Blood disease
☐ Bruise easily
☐ Cancer
☐ Chemotherapy / Radiation therapy
☐ Chronic cough

☐ Cold sores / Fever blisters
☐ Cortisone medicine
☐ Diabetes
☐ Diet (special / restricted)
☐ Emphysema
☐ Epilepsy / Convulsions
☐ Excessive bleeding
☐ Fainting / Dizzy spells
☐ Glaucoma
☐ Hay fever / Allergy / Hives
☐ Heart (disease, attack, or surgery)
☐ Heart murmur
☐ Hemophilia
☐ Hepatitis: ☐ A ☐ B ☐ C
☐ High blood pressure or
☐ Low blood pressure
☐ High cholesterol
☐ Hormone replacement treatment
☐ Kidney trouble
☐ Latex sensitivity
☐ Liver disease / Yellow jaundice
☐ Migraines
☐ Multiple sclerosis

☐ Nervous / Anxious
☐ Neurological disorders
☐ Osteoporosis
☐ Pacemaker / Defibrillator
☐ Parkinson's Disease
☐ Psychiatric / Psychological care
☐ Respiratory Problems
☐ Rheumatic fever
☐ Sickle Cell disease
☐ Seizures
☐ Sinus problems
☐ Sexually transmitted diseases
☐ Special Needs
Type:

Functions at age:

☐ Stint (brain or spine)
☐ Stroke
☐ Substance abuse
☐ Swollen ankles
☐ Thyroid problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Use of CPAP machine /
Oral sleep devices

Consent for Services/Assignment of Benefits:
After my exam, I authorize the doctor to perform the necessary treatment as needed. I authorize the release of any information relating to dental treatment to third party payers and/or other health practitioners for myself or my dependents by Spring Valley Dental Group / provider. I authorize my doctor to submit claims to be submitted for my dependents or myself. I understand that all insurance payments will be made directly to the doctor, unless otherwise specified by me.

I have read the above conditions of treatment and agree to their contents.

Signature of Patient, Parent or Guardian: **Date:**

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MEDICAL INFORMATION RELEASE FORM
(HIPAA Release Form)

Name: **Date of Birth:**

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse:

☐ Children:

☐ Other:

☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call my: ☐ Home ☐ Work ☐ Cell Phone:
Phone number: **( )**

If unable to reach me:
☐ You may leave me a detailed message
☐ Please leave a message asking me to return your call
☐

The best time to reach me is:
Day:

Time:

Patient Signature: Date:

Witness: Date:

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NOTICE OF PRIVACY PRACTICES

Protecting your health information is important to us

So what has changed?

The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information, such as: our computers, internet, phone, faxes, copy machines and charts.

We will use and communicate your HEALTH INFORMATION only for purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for purposes unless we have asked for and been given your permission.

TO PROVIDE TREATMENT

We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies, or other health care personnel providing you treatment.

TO OBTAIN PAYMENT

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. It is possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care. These communications are an important part of our philosophy of partnering with patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, telephone, or electronic reminders such as E-mails (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we believe we are specifically required or authorized by law, we do not need your permission to report abuse or neglect.

Public Health and National Security

We may be required to disclose to federal officials or military authorities health information necessary to complete an investigation related to public health. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of the new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our best judgement when sharing your information only when it will be important to those participating in providing your care.

Patient Rights

Our office will make every effort to honor reasonable restriction preferences from our patients. You have the right to request restrictions.

Confidential Communications

You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including; your complete chart, x-rays, and billing records.*

Amend your Health Information

You have the right to ask us to update or modify your records if you believe our records are incorrect or incomplete. Your request may be denied if the information record in question was not created by our office or is not part of our records.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than treatment, payment or health operations. This can be no more than one request in a six year period. *

Request a Paper Copy of This Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time.

We have required by law to maintain the privacy of our health information and to provide to you and your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or the Secretary of Health and Human Services if you believe your rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know your concerns of complaints in writing. * We may need to charge you a reasonable fee to duplicate and assemble your copy.

Patient Acknowledgement

Patient Name(s):

_____

_____

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions we want to hear from you.

Patient/ Guardian

Sign:

_____

Date:

_____

SUBMIT