SPRING VALLEY
DENTAL CARE

Patient Information

We are thrilled you have chosen us to provide you with excellent dental care. We understand that dentistry can sometimes be expensive, time consuming, and inconvenient. We vow to help in any way we can to make dental care as easy and affordable as possible. Your satisfaction is our #1 goal. If there is anything we can do to help you, please let our staff know!

First Name: _____ Middle: _____ Last: _____ Preferred Name: _____

How did you hear about our office? _____ Do you use a

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Birth Date: ____ / ____ / ____ Age: _____ Height: _____ Weight: _____ Sex: Male / Female

Social Security Number: _____ - _____ - _____
(For Insurance and Billing – Your information will be guarded with our HIPPA Compliant Computer Systems)

Would you like us to contact you via text and/or e-mail to confirm appointments? Yes / No

E-mail Address: _____ Do you use an HRA or HSA Account? Yes / No

Emergency Contact Name: _____ Relationship: _____ Phone: (____) _____ - _____

List names of with whom we may discuss your treatment and account information: _____

Please provide a valid driver's license for us to copy for identity verification purposes when you return these forms

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Dental Insurance (If Applicable)

Subscriber for This Policy's First Name: _____ Middle Initial: ____ Last Name: _____

Subscriber's Relationship to Patient: _____ Subscriber's Birth Date: ____/____/____

Subscriber's Social Security Number: ____ - ____ - _____ Insurance Company: _____

Subscriber's Employer: _____ Group Number: _____

Subscriber ID: _____ Insurance Phone Number: (____) _____ - _____

Responsible Party (If Other Than Patient Or Insurance Subscriber)

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Birth Date: ____ / ____ / ____ Age: _____ Social Security Number: ____ - ____ - _____

HIPAA/Privacy Practices
Legal Rights Regarding Your Personal Information

I understand that my healthcare information concerning my diagnosis, treatment, payment, and insurance will be disclosed only when necessary for filing my insurance and in communication with other health care professionals in the course of treatment of their offices. Limited information will also be disclosed to businesses supporting operations of this office such as dental or medical labs, hospitals, accountants, billing personnel, customer support, answering service, and consultants.

Their businesses are restricted in uses and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose to that family member or person.

I understand that my files are stored on a computer database. Only staff and janitorial personnel may have access to this office during non-business hours. I understand that this office will make every effort to keep my information secure and correct any violation of my privacy if this should occur.

I understand that I have the right to access, copy, or inspect my healthcare information; the right to restrict disclosures, and obtain an accounting of disclosures. I have the right to voice my concerns about privacy to the practice and/or The Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by the office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure. A minimal fee of $.25 per page will be charged to me for copies of records that I request.

I understand that I will receive communication in the form of phone calls, e-mails, text messages, and/or post cards to remind me of an existing appointment, or that it is time to schedule an appointment. I may receive mail containing financial information. Communication may also be sent to me in the form of fax, e-mail, or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home or work voicemail.

I have read and understand this office policy. I understand that by signing this agreement, I give permission for the use and disclosure of my personal and health information in order to carry out treatment, payment, insurance claims, and healthcare operations. This office retains the right to revise this privacy policy.

Patient/Guardian Signature: _____ Date: ___ / ___/ ___

Financial & Insurance Information

All Patients

Please read and sign our consent forms before each procedure so that you have the right expectations regarding the longevity of your dental work. Also be aware of the **leading factors that cause problems with restorative dentistry**: 1) Bruxism (tooth grinding) 2) Medications (pharmaceutical or recreational) 3) Poor home hygiene and failure to have regular professional cleanings.

Summary - Patients Without Insurance

We understand that dental expenses can often be frustrating and unexpected. We will make every effort to help you proceed at a comfortable pace and to have all the best options. We also work with third party financing to help make dentistry affordable. We encourage you to use our Membership Program. At the same time we request that payments be made at the time of service.

Patients With Insurance

For the most part, we rarely have problems establishing your Estimate and Patient Responsibility. However, we would like to warn you of some rare occurrences…. Dental insurance companies can be confusing and deceptive at times whether intentional or not. Despite having access to the top computer systems in the business, SVDC is only able to **estimate** your benefits (usually accurate within 10s of dollars). We make every effort to maximize your benefits, however, even though we may call the insurance company on your behalf or submit for a **"Preauthorization"** we still can **only estimate** the Total Billed Amount and The Patient Responsibility. Unfortunately, even with Preauthorization nothing is set in stone until the procedure is completed and the Insurance Company sends payment and a Final Determination. **Your estimated portion is due at the time of service**. And, it is the patients' responsibility to make sure that the **Total Billed Amount** is paid even if the insurance company changes their mind and decides not to pay their portion after the fact. They are a **"For Profit Business"** and often times there is a conflict of interest when it comes to paying claims versus the **standard of care and basic oral health**. There are many **restrictions** including – but not limited to – Waiting Periods, Frequency of Treatment, Deductibles, Exclusions, and Non-Coverage for Basic Treatment.

Your dental benefits are **based upon a contract made between your employer and your insurance company**. We will do our best to use our computer systems to help you maximize your benefits, but if you have any further questions regarding your dental benefits that we could not uncover for you on your behalf, please contact your employer or your insurance company directly. **Dental insurance is more of a "benefit" than an "insurance."** Even the best dental benefit plans rarely pay for 100% completion of your dental care. An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in the survey are Medicaid clinics and managed care facilities, which have several reduced dental fees and sometimes less than stellar care that bring down the fee but also the quality. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary." Many dental benefit plans tell their participants that they will be covered "up to 50%, 80% or 100%," but do not clearly specify the plan fee schedule allowance, annual maximums, or limitations. It is more realistic to expect dental benefits to cover between 25%-60% of dental services. **We will review specifics with you after diagnosis.** Often, Insurance Companies do not recognize many routine dental services such as implants, white fillings, white crowns and occlusal guards.

Financing Options & Other Financial Information

We will collect estimated co-payments and deductibles on the day services are rendered. A finance charge may be added to your account after 90 days of no account/payment activity, or your account could be turned over to an **outside collection agency** which may affect your credit score. **Patients are expected to pay in full by cash, check, or major credit card the day services are rendered, unless financial arrangements have been made prior to treatment beginning.** For your convenience, we do offer third party financing for your dental visits which may be interest free Please feel free to ask someone about this service.

If you understand and agree to the above guidelines for our office, please sign below.

Patient/Guardian Signature: _____ Date: ___ / ___/ ___

Cancelling & Quality Assurance Policies

Why do we have a cancellation policy?

- In order to reserve specific appointment time for each patient
- To deliver treatment in an efficient, convenient, and timely fashion for all patients
- To respect everyone's time including you, our team and other patients

We will make every effort to provide service in a timely manner. We understand that your time is valuable and want everyone's appointment to be as convenient as possible. We work with a structured appointment system to keep an efficient run dental office.

We make every effort to honor all time commitments and we hope that our patients would do the same for us. Please help us achieve this goal by making every effort to be early for your appointments and we will do the same.

******One Business Day – Cancellation / Reschedule Policy******

If you are unable to keep your reserved appointment for any reason, please notify us at least **one full business day** in advance of your scheduled time otherwise the greater of a **$50 cancellation fee or forfeit of your deposit will be applied**. When patients violate this policy more than three times within a calendar year, the patient may be dismissed from our office or we ask that they call for possible same-day availability. This applies to changing the appointment time and keeping the same day. **The policy is enforced regardless of the reason (car troubles, illness).**

What if I am Late?

If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment or you may wait until a provider is available. If you are running behind **please call (201) 843-3312 or text (201) 759-5597** so we can work to accommodate you. When patients violate this policy more than three times within a calendar year, the patient is kindly dismissed from our office or we ask that they call for possible same-day availability.

Quality Assurance and Educational Recordings

For educational, quality assurance, and marketing purposes we may take photos or record conversations either on the telephone or in person. This enables us to better train our staff and become the best dental office we can possibly be! We will always conceal your identity for privacy purposes.

Cell Phones & Other Electronics

For safety reasons and to ensure the best clinical outcomes. Please refrain from using cell phones and other electronic devices during procedures unless one of our team members says that it is safe to do so.

Can I be in the room with my loved one?

For safety purposes and to allow for our team to deliver the best care, no one other than the patient is permitted in the treatment rooms. If you are a parent or guardian, then it is okay to be present during the treatment plan. However, once you agree to treatment we ask that you to kindly wait in the reception area if possible.

If you understand and agree to the above guidelines for our office, please sign below. If you have any concerns please let us know!

Patient/Guardian Signature: _____ Date: ___ / ___/ ___

Health History – Your overall health may effect your dental treatment

General Health

- What was the approximate date of your last medical exam? _____
- Are you under a doctor's care now for a disease? ☐ No ☐ Yes, please explain: _____
- Have you ever been hospitalized or had a major operation? ☐ No ☐ Yes, please explain: _____
- Have you ever had a serious head or neck injury? ☐ No ☐ Yes, please explain: _____
- Do you have trouble driving a car? ☐ No ☐ Yes, please explain: _____
- Do you have any trouble climbing one flight of stairs? ☐ No ☐ Yes, please explain: _____

Female Patients

- Are you pregnant / trying to get pregnant? ☐ No ☐ Yes, what is your due date? _____
- Are you taking oral contraceptives? ☐ No ☐ Yes
- Are you Nursing? ☐ No ☐ Yes

Allergies Do you have allergies? ☐ None OR Check those that apply: ☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Penicillin ☐ Metal ☐ Sulfa Drugs ☐ Other: _____

What are your symptoms? _____ How do you treat the symptoms? _____

- Have you ever been prescribed Epi-Pen? ☐ No ☐ Yes, Please Explain: _____

Medications

- Have you ever taken Fosamax, Boniva, Actonel or any bisphosphonates? ☐ No ☐ Yes, please explain: _____
- Do you use tobacco? ☐ No ☐ Yes, frequency: _____
- Did you quit using tobacco? ☐ No ☐ Yes, quit date: _____
- Do you use controlled substances? ☐ No ☐ Yes, please explain: _____
- Please list any medications / pills / drugs (prescription or recreational) you are currently taking?

_____

_____*Please note: Any of the above medications or recreational drugs may cause tooth decay. Be sure to ask our dentists)*

Please circle any of the following you have ever had:

AIDS/HIV Positive	Cortisone Medication	Hepatitis B	Renal Dialysis
Alzheimer's Disease	Diabetes	High Blood Pressure	Rheumatic Fever
Anaphylaxis	Dizziness	High Cholesterol	Rheumatism
Anemia	Drug Addiction	Hives or Rash	Scarlet Fever
Angina	Easily Winded Emphysema	Hypoglycemia	Shingles
Arthritis / Gout	Epilepsy Seizures	Irregular Heartbeat	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Kidney Problems	Sinus Trouble
Artificial Joint	Excessive Thirst	Leukemia	Snoring / Sleep Apnea
Asthma	Fainting Spells /	Liver Disease	Spina Bifida
Blisters	Frequent Cough	Low Blood Pressure	Stomach/Intestinal Ds
Blood Disease	Frequent Diarrhea	Lung Disease	Stroke
Blood Transfusion	Frequent Headaches	Mitral Valve Prolapse	Swelling Limbs
Breathing Problem	Genital Herpes	Neck Pain	Thyroid Disease
Bruise Easily	Glaucoma	Osteoporosis	Trouble Sleeping
Cancer	Hay Fever	Pacemaker/Defibrillator	Tuberculosis
Chemotherapy	Heart Attack/Failure	Pain in Jaw Joints	Tumors/Growths
Chest Pain	Heart Murmur	Parathyroid Disease	Ulcers
Cold Sores / Fever	Heart	Psychiatric Care	Venereal Disease
Congenital Heart Dis.	Heart Trouble/Disease	Radiation Treatments	Waking Up To Urinate
Congestive Heart Failure	Hemophilia	Radical Weight Loss	Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ No ☐ Yes, please explain: _____

Do you have other comments?: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature: _____ Date: ___ / ___/ ___

Smile Evaluation

When were you last at the dentist? ☐ 6 months ☐ 1-2 years ☐ 3-5 years ☐ 5+years

What is your main concern today?

Sedation: ☐ Nitrous ☐ Moderate Sedation ☐ Deep Sedation
Hygiene: ☐ Cleaning ☐ Gum Disease
Urgent: ☐ Sensitivity ☐ Pain (now) ☐ Pain (sometimes) ☐ Broken Tooth ☐ Cavities/Decay
Cosmetic: ☐ Whitening ☐ Old Work ☐ Silver Fillings / Amalgam Replacement
Wisdom Teeth: ☐ Wisdom Teeth
Missing Teeth: ☐ Dentures ☐ Overdentures ☐ Implant Bridge / All-On-4
TMJ: ☐TMJ ☐ Clenching ☐Grinding ☐ Jaw & Tooth Pain
Orthodontics: ☐ Braces ☐ Invisalign

Do you have any anxiety or fear when it comes to dentistry? ☐ None ☐ Low ☐ Medium ☐ High Anxiety
Have you had any bad experiences? _____

Do you like the appearance of your smile and look of your teeth?
☐ Yes ☐ No What would you most like to change? _____

What is most important to you when seeking dental treatment?

☐ Cleanliness of Office ☐ Comfort ☐ Convenient Office Hours
☐ Cost ☐ Fear/Sedation ☐ Friendliness of Staff
☐ Quality of Service ☐ Technology

Home Care

How many times a week do you brush? _____
How many times a week do you floss? _____
Do you have bad breath (halitosis)? No / Yes
Do you clench or grind your teeth? No / Yes

Prior Treatment

Have you ever had periodontal gum treatment (deep cleaning or gum grafting)? No / Yes

Have you ever had orthodontic treatment (braces)? No / Yes

Have you had your wisdom teeth removed? No / Yes

Have you ever had sedation dentistry before? No / Yes, please explain: _____

Today

May we take necessary dental x-rays in order to provide you with accurate diagnosis? No / Yes

If we find an issue that should be addressed immediately are you interested in having treatment done today? No / Yes

Is there friend or family member who you would us to speak with regarding the outcome of your exam? No/Yes, if yes who? _____

SPRING VALLEY
DENTAL CARE

Phone: (201) 843-3312
Text: (201) 759-5597

Emergency Phone: (201) 843-3312
or
call 911

Email: springvalleydental930@gmail.com

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Is there anything else you would like for us to know about you, please explain? _____

_____

Patient/Guardian Signature: _____ Date: ___ / ___/ _____

Doctor's Notes/Interview: _____

_____

_____

_____

Internal Use:

☐ Insurance verified

Doctor Signature: _____ Date: ___ / ___/ _____