Canyon Falls Dental

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

PATIENT INFORMTAION
(PLEASE PRINT)

Date________/_______/________

Patient____

Last Name First Name Middle Initial Preferred Name

Mailing Address ___________________________________ City_________________ State________ Zip_________

Sex□ M□ F Age_________ Birth date_____/______/______ Patient Social Security#_________-_________-_________

Home Phone (_______) __________-__________ Cell Phone (_______) ________-_________ Work (_______) _________-_______

Employer/School___________________________________ Occupation__________________________________

If Minor, Parent/Guardian Name _________________________________ Parent / Guardian D.O.B._______/_______/________

Parent/Guardian SSN #__________-___________-_____________ Email____________________________________

Emergency Contact_____________________________ Relationship to Patient___________________________

Phone Number (_______) _______-_________ Whom may we thank for referring you? __________________________

MEDICAL HISTORY

Have you ever had any of the following? (**Check All that apply**):

- □ Allergies (seasonal)
- □ Arthritis
- □ Artificial Heart Valves or
  - □ Joints, □Screws, etc.
- □ Back Problems
- □ Bleeding abnormally
- □ Blood Disease
- □ Cancer
- □ Chemical Dependency
- □ Circulatory Problems
- □ Congenital Heart Lesions
- □ Depression
- □ Diabetes
- □ Epilepsy
- □ Fatigue
- □ Gasp for air while sleeping
- □ Headaches/Morning
- □ Heart Murmur/Problems
- □ Hemophilia
- □ Hepatitis
  - □A, □B, □C, □D
- □ High Blood Pressure
- □ HIV/AIDS
- □ Jaundice
- □ Liver Disease
- □ Low Blood Pressure
- □ Mitral Valve Prolapse
- □ Nervous Problems
- □ Overnight Sleep Study
- □ Pacemaker
- □ Psychiatric Care
- □ Radiation Treatment
- □ Recent Weight Loss
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Sinus Problems
- □ Sleep Apnea
- □ Snoring
- □ Special diet
- □ Swollen Neck Glands
- □ Ulcer
- □ Venereal Disease
- □ OTHER____________________

Physician's Name_______________________________________ Date of Last Physical ___________/___________/_____________

Are you under the care of a physician? □YES □NO For what conditions? ____

Are you currently taking any medication? □YES □NO If so, what? ____

Do you have any drug allergies, or have you ever had an adverse reaction to any medication or anesthesia? □Yes □ No

If so, what? ____

Have you ever responded adversely to medical or dental treatment? □Yes □No If so, when? ________________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" □Yes □ No

Women:

Are you pregnant? □Yes □No If yes, what is your due date_________/___________/__________

Are you Nursing? □Yes □No Are you taking birth control pills? □Yes □No

OVER ⟶

PRIMARY PERSON RESPONSIBLE FOR ACCOUNT

Name: ________________________________ Birth date________/________/________ Relationship ______________________

Phone Number (_______) ___________-____________ S.S.N. _________-_________-_________ Sex □ M □ F

Mailing Address ____________________________________ City__________________ State________ Zip_________

Employer_____________________________________ Work (_______) _________-________ Occupation_________________

Spouse/ Other Parent/Legal Guardian Information

Name: ________________________________ Birth date________/________/________ Relationship ______________________

Phone Number (_______) ___________-____________ S.S.N. _________-_________-_________ Sex □ M □ F

Mailing Address ____________________________________ City__________________ State________ Zip_________

Employer_____________________________________ Work (_______) _________-_______ Occupation_________________

Dental Insurance (Primary)

Name of Primary Insured________________________ D.O.B._____/_____/_______ S.S.N_______-_______-________

Name of Employer_______________________________ Group Number _____________________

Name of Dental Insurance Company _______________________________Subscriber/PolicyNumber________________

Dental Insurance (Secondary)

Name of Primary Insured________________________ D.O.B._____/_____/_______ S.S.N_______-_______-________

Name of Employer_______________________________ Group Number _____________________

Name of Dental Insurance Company _______________________________Subscriber/PolicyNumber________________

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of

____

(Please Print Name of Minor/Child)

and I am not legally prohibited from signing this consent. By signing below, I request and authorize the dental staff to perform necessary dental services for the above-named child, including but not limited to x-rays, emergency treatment, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that myself and/or my dependent(s) is(are) covered by insurance with

____	____
Primary	**Secondary**

INSURANCE

________ Our office understands the value of insurance benefits, and we are happy to assist you in filing the necessary forms. This is done as a courtesy to our patients and there is no guarantee of coverage. The insurance carriers base the amount of benefits on a fee schedule that they arbitrarily developed. For this reason, you may receive less of a benefit than we estimate for you. Your insurance policy is an agreement between you and your insurance carrier; therefore, all patients are directly responsible for all charges. Once your insurance carrier has paid, you will be responsible for any difference upon receipt of our statement. If for any reason your insurance carrier has not paid within 60 days from the date of treatment, you are responsible for the entire balance at that time.

FINANCIAL AGREEMENT

________ I acknowledge that payment is due at the time of treatment. I agree that as parents/ guardians/ personal representatives I/We are responsible for all charges of any services/treatment rendered of minor/child. I accept full financial responsibility for all charges of services/treatment or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

________ Unpaid balances may be assessed a monthly charge of two percent (2%). If, for any reason, we must resort to collecting money owed to Canyon Falls Dental either through a collection agency or some other means, the patient or guardian will be responsible to pay all collection fees and/or interest charged for past due accounts

APPOINTMENT CONFIRMATION POLICY

________ As a courtesy, Canyon Falls Dental will reach out via phone/text before the appointments to remind the patient about the scheduled time and answer any questions he/she may have. If the patient does not receive a call, he/she will still be expected to come to their appointment on time.

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least **24** hour notice for any cancelled appointment. The second and subsequent broken appointments the patient will be assessed **a $50 "broken appointment." fee**

A broken appointment is defined as:

a. A patient not showing for a scheduled appointment or showing too late for treatment to be done.

b. An appointment cancelled with less than 24 hours' notice.

We value our patients and hate to see them go, but 3 or more "broken appointments." in a 12-month period may result in being discharged from our dental practice.

Canyon Falls Dental is open on Saturdays as a convenience to our patients. Due to the demand for weekend appointments, Saturdays are considered a **"NO CANCEL"** day. If a Saturday appointment is broken with less then 24 hours' notice, the patient will be ineligible for future Saturday appointments.

CERTIFICATION

The information provided on this form is complete and correct to the best of my knowledge. I understand that it is my responsibility to inform my doctor prior to treatment if I myself or my minor child ever has a change in health condition.

INITIAL and SIGN BELOW

_______ I have read and understand all the above information provided by Canyon Falls Dental.

____	______________________________
Patient's/ Parent or Guardian's Signature	**Date**