



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

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:**



<b>Patient's Name:</b>		<b>Date of Birth:</b>
<b>If Minor – Parent's Name:</b>		
<b>DENTAL HISTORY</b>		
<b>Have you been having any specific problems?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:		
<b>Last Dental visit:</b>	<b>Purpose:</b>	<b>Last Complete Exam:</b>
<b>Previous Dentist's Name:</b>		<b>Phone Number: (    )</b>
<b>Has fear or discomfort kept you from regular visits?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Is your dental health:</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<b>Do you feel decay?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Gum Disease?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>How often do you brush your teeth?</b>		<b>How often do you floss?</b>
<b>What other dental aids do you use (electric toothbrush, waterpik, etc.)? :</b>		
<b>How do you feel about your smile?</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <b>Is there anything you'd like to change about your smile?</b>		
<b>Are you interested in whitening your teeth?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Are you interested in straightening your teeth?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Would you be interested in a Juvéderm or Botox treatment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Have you ever been told to take a pre-medication prior to dental treatment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe why:		
<b>Is there anything else about having dental treatment that you would like us to know?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:		
<b>MEDICAL HISTORY</b>		
<b>Name of your Physician:</b>		(if you do not have a physician, please write none.)
<b>Last Exam:</b>	<b>Phone Number: (    )</b>	
<b>Women: Are you pregnant or think you could be pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Expected Delivery Date:</b>
<b>Are you taking birth control?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Nursing?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Are you under a doctor's care now?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If so, for what reason?		
Current use of any tobacco products? <input type="checkbox"/> None <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigar <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Other		
<b>Because of anesthetic, we need to know if you currently or have used any street/illicit drugs. If so, please list:</b>		



**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.**

<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Acid Reflux / GERD <input type="checkbox"/> Allergy to <input type="checkbox"/> Medications <input type="checkbox"/> Anesthetic <input type="checkbox"/> Seasonal allergies List: <hr/> <input type="checkbox"/> Angina / Chest pain <input type="checkbox"/> Anti-depression treatment <input type="checkbox"/> Arthritis / Rheumatism Type: <hr/> <input type="checkbox"/> Artificial heart valves Date: <hr/> <input type="checkbox"/> Artificial joints Date: <hr/> <input type="checkbox"/> Aspirin treatment / Blood thinner <input type="checkbox"/> Asthma / Inhaler <input type="checkbox"/> Blood disease <input type="checkbox"/> Bruise easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy / Radiation therapy <input type="checkbox"/> Chronic cough	<input type="checkbox"/> Cold sores / Fever blisters <input type="checkbox"/> Cortisone medicine <input type="checkbox"/> Diabetes <input type="checkbox"/> Diet (special / restricted) <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy / Convulsions <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Fainting / Dizzy spells <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hay fever / Allergy / Hives <input type="checkbox"/> Heart (disease, attack, or surgery) <input type="checkbox"/> Heart murmur <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> High blood pressure or <input type="checkbox"/> Low blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hormone replacement treatment <input type="checkbox"/> Kidney trouble <input type="checkbox"/> Latex sensitivity <input type="checkbox"/> Liver disease / Yellow jaundice <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Nervous / Anxious <input type="checkbox"/> Neurological disorders <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker / Defibrillator <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Psychiatric / Psychological care <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Sickle Cell disease <input type="checkbox"/> Seizures <input type="checkbox"/> Sinus problems <input type="checkbox"/> Sexually transmitted diseases <input type="checkbox"/> Special Needs Type: <hr/> Functions at age: <hr/> <input type="checkbox"/> Stint (brain or spine) <input type="checkbox"/> Stroke <input type="checkbox"/> Substance abuse <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors <input type="checkbox"/> Ulcers <input type="checkbox"/> Use of CPAP machine / Oral sleep devices
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**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:**



**MEDICAL INFORMATION RELEASE FORM  
(HIPAA Release Form)**

**Name:**

**Date of Birth:**

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**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:

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Children:

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Other:

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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: (       )

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If unable to reach me:

You may leave me a detailed message

Please leave a message asking me to return your call

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The best time to reach me is:

Day:

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Time:

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Patient Signature:

Date:

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Witness:

Date:

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**NOTICE OF PRIVACY PRACTICES**  
Protecting your health information is important to us

<b>NOTICE OF PRIVACY PRACTICES</b> Protecting your health information is important to us			
<p><b>So what has changed?</b></p> <p>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.</p> <p>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.</p> <p><b>TO PROVIDE TREATMENT</b></p> <p>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.</p> <p><b>TO OBTAIN PAYMENT</b></p> <p>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.</p> <p><b>To Conduct Health Care Operations</b></p> <p>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.</p>	<p><b>In Patient Reminders</b></p> <p>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).</p> <p><b>Abuse or Neglect</b></p> <p>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.</p> <p><b>Public Health and National Security</b></p> <p>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.</p> <p><b>For Law Enforcement</b></p> <p>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.</p>	<p><b>Family, Friends and Caregivers</b></p> <p>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.</p> <p><b>Patient Rights</b></p> <p>Our office will make every effort to honor reasonable restriction preferences from our patients. You have the right to request restrictions.</p> <p><b>Confidential Communications</b></p> <p>You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed.</p> <p><b>Inspect and Copy Your Health Information</b></p> <p>You have the right to read, review and copy your health information, including; your complete chart, x-rays, and billing records.*</p> <p><b>Amend your Health Information</b></p> <p>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.</p> <p><b>Documentation of Health Information</b></p> <p>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. *</p>	<p><b>Request a Paper Copy of This Notice</b></p> <p>You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time.</p> <p>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.</p> <p>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.</p> <p><b>Patient Acknowledgement</b></p> <p><b>Patient Name(s):</b></p> <hr/> <hr/> <p>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.</p> <p><b>Patient/ Guardian</b></p> <p>Sign:</p> <hr/> <p>Date:</p> <hr/>