



Welcome to Crystal Falls Dental,

We're excited that you've decided to visit our office. We look forward to getting to know you and want to address all of your dental concerns. We appreciate your business and would be delighted to serve your family & friends as well.

We look forward to making this a comfortable dental home for you.

Warm Regards,

Our friendly team at Crystal Falls Dental



We strive to make your dental visits as pleasant and comfortable as possible. Please help us by completing this form.

**Patient Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Drivers License \_\_\_\_\_

Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Phone: Home \_\_\_\_\_ Social Security # \_\_\_\_\_

Work \_\_\_\_\_ May we contact you at work? \_\_\_Yes \_\_\_No

Mobile \_\_\_\_\_ Gender: \_\_\_Female \_\_\_Male

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relation \_\_\_\_\_

**Insurance**

**Primary Dental Carrier**

Subscriber \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Relation to Patient \_\_\_\_\_

**Insurance Authorization Statement (Sign & Date)**

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relation to Patient \_\_\_\_\_



**Dental History**

How did you hear about us? \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

What would you like to change about your smile? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

What did you like **most** about your last dentist? \_\_\_\_\_

Do your gums bleed while brushing or flossing? \_\_\_\_\_

Do you grind your teeth? \_\_\_\_\_

Do you snore or does your significant other snore? \_\_\_\_\_

Have you ever had prolonged bleeding after an extraction or surgery? \_\_\_\_\_

Please note if you are interested in any of the following:

- |  |  |
|--|--|
| <input type="checkbox"/> Invisalign – Clear Braces | <input type="checkbox"/> More Attractive Smile   |
| <input type="checkbox"/> Implants                  | <input type="checkbox"/> Veneers / Lumineers     |
| <input type="checkbox"/> Bad Breath Treatment      | <input type="checkbox"/> Fixing Chipped Teeth    |
| <input type="checkbox"/> Closing Gaps in Teeth     | <input type="checkbox"/> Replacing Missing Teeth |
| <input type="checkbox"/> 6 Month Braces            | <input type="checkbox"/> Preventing Cavities     |

How would you like to receive appointment reminders?

- Text       Email      *OR*       Neither

(If you don't mark anything, you will receive both.)

**Medical History and Information**

**Conditions (Please mark ONLY what applies to you)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> Drug Use            | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> Alcohol Abuse           | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Joint Replacement     |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Kidney Problems       |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Facial Surgery      | <input type="checkbox"/> Liver Disease         |
| <input type="checkbox"/> Angina Pectoris         | <input type="checkbox"/> Fainting Spells     | <input type="checkbox"/> Low Blood Pressure    |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Fever Blisters      | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Frequent Headaches  | <input type="checkbox"/> Pace Maker            |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Psychiatric Problems  |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> HIV/ AIDS           | <input type="checkbox"/> Radiation Therapy     |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Rheumatic Fever       |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Colitis                 | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> STD's                 |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Shingles              |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Thyroid Problems    | <input type="checkbox"/> Sickle Cell Disease   |
| <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Ulcers                  |  |  |

If you have marked any of the above, please explain each further. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to anything (including Penicillin, Amoxicillin or Latex)? \_\_\_\_\_  
 Female Only: Are you pregnant? \_\_\_\_\_ If so, how many weeks? \_\_\_\_\_  
 Please list any medications you are currently taking: \_\_\_\_\_  
 \_\_\_\_\_

**Treatment Authorization Form**

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary as advisable; including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

I also understand that payment for all treatment and services rendered are my responsibility.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Patient Agreement**

Welcome,

At Crystal Falls Dental, we believe that you deserve the best care. That’s why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Here is some information regarding methods of payment as well as insurance information.

Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly.** Dental benefit plans will not usually pay for completion of your dental care. It is only meant to assist you.

We currently accept all private care insurance plans or PPO’s (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change regularly; therefore it is **impossible** to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your exact insurance benefit, we will be happy to file a “pre-treatment authorization” with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket you may require.

Many people receive notification from their insurance company that dental fees are “above usual and customary.” An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as “higher than usual and customary.”

As a courtesy, we bill your insurance for you. We are a ‘fee for service’ establishment, so payment will be due at the time of treatment.

**Broken Appointments:** A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **\$25/hour cancellation fee** (emergencies are an exception).

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you’ve always wanted. If there is anything we can do to make your visits here more pleasant, please don’t hesitate to ask one of our staff members.

Name (Print): \_\_\_\_\_

Sign: \_\_\_\_\_

Date: \_\_\_\_\_