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:

___ Invisalign – Clear Braces

___ Implants

___ Bad Breath Treatment

___ Closing Gaps in Teeth

___ 6 Month Braces

___More Attractive Smile

___ Veneers / Lumineers

___ Fixing Chipped Teeth

___ Replacing Missing Teeth

___ Preventing Cavities

How would you like to receive appointment reminders?

___ Text ___ Email *OR* ___Neither

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

CRYSTAL FALLS DENTAL
FAMILY AND COSMETIC DENTISTRY

Medical History and Information

Conditions (Please mark ONLY what applies to you)

___ Abnormal Bleeding	___ Drug Use	___High Blood Pressure
___ Alcohol Abuse	____Emphysema	___ Joint Replacement
___ Allergies	___ Epilepsy	___ Kidney Problems
___ Anemia	___ Facial Surgery	___ Liver Disease
___ Angina Pectoris	___ Fainting Spells	___ Low Blood Pressure
___ Arthritis	___ Fever Blisters	___ Mitral Valve Prolapse
___ Artificial Heart Valve	___ Frequent Headaches	___ Pace Maker
___ Asthma	___ Glaucoma	___ Psychatric Problems
___ Blood Transfusion	___ HIV/ AIDS	___ Radiation Therapy
___ Cancer	___ Heart Attack	___ Rheumatic Fever
___ Chemotherapy	___ Heart Murmur	___ Seizures
___ Colitis	___ Hemophilia	___ STD's
___ Congenital Heart Defect	___ Hepatitis A, B or C	___ Shingles
___ Diabetes	___ Thyroid Problems	___ Sickle Cell Disease
___ Difficulty Breathing	___ Tuberculosis	___ Stroke
___ 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:______________________________