Patient Information  Confidential

(*Please Print Legibly*)

Date: _____

PERSONAL INFORMATION

Name: _____Birth Date: _____

Address: _____

City: _____State: _____ Zip: _____

Telephone: (Home)_____(Cell)_____

email: _____SS#: _____

Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred By: _____

PERSON RESPONSIBLE FOR ACCOUNT

Check box if same as above ☐ (If someone other than above, please fill out)

Name: _____ Relationship: _____ SS#: _____

Address: _____

City: _____State: _____ Zip: _____

Telephone: (Home)_____(Work)_____

DENTAL INSURANCE INFORMATION

Check box if you have dental insurance ☐

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

Signature	**Date**

Patient Information  Confidential

(*Please Print Legibly*)

HEALTH INFORMATION

Personal Physician Name: _____Phone:_____

YES	NO	
☐	☐	1. Have you been hospitalized within the past 2 years? For What? _____
☐	☐	2. Are you currently being treated by a physician? For What?_____
☐	☐	3. Are you currently taking any medicines or drugs? What?_____
		_____
☐	☐	4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
☐	☐	5. Are you allergic to any drugs? What?_____
☐	☐	6. Have you ever had a skin rash or other reaction to metal jewelry? To what?_____
☐	☐	7. Are you allergic to any metals? What?_____
☐	☐	8. Have you ever had a total joint replacement?_____
☐	☐	9. Are you pregnant?
☐	☐	10. Do you use any form of tobacco?
☐	☐	11. Do you bleed excessively upon injury?

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR NOW HAVE

A. AIDS	F. Epilepsy	K. High Blood Pressure	P. Rheumatic Fever
B. Arthritis	G. Glaucoma	L. Jaundice	Q. Sexually Transmitted Diseases
C. Asthma	H. Heart Murmur	M. Kidney Problems	R. Stroke
D. Cancer	I. Heart Problem*	N. Low Blood Pressure	S. Tuberculosis
E. Diabetes	J. Hepatitis	O. Nervous Breakdown or Psychiatric Therapy	T. Other Diseases*

*If you circled either I or T describe condition:_____

EMERGENCY CONTACT (OTHER THAN IMMEDIATE FAMILY)

Name: _____

Address: _____

Telephone: (Home) _____ (Cell)_____

Signature	**Date**

Cherrington Dental

General Information

Thank you for your interest in our practice. At Cherrington Dental our goal is to provide you with the highest quality and most comprehensive care possible. The care we provide is specific to each person's needs and circumstances.

Regarding health history and treatment: It is important that you are informed about your dental health and any required treatment and that you give your informed consent before starting any dental treatment. It is your responsibility to inform us of any conditions related to your health including: health status, diseases, surgeries, or other risk factors.

Scheduling Requirements: We value your time and work diligently to accommodate your schedule. In return we ask that our patients keep their scheduled visits faithfully. We do not overbook our doctors so that you are able to enjoy little to no wait time at your visits. Failure to keep scheduled visits harms our ability to help other patients who are waiting for needed dental treatment and would have taken that time. In summary, here are our attendance guidelines:

- **It is your responsibility to keep your reserved visits and show up on time**
- **As a courtesy, we will remind you in advance of those reserved times using all means possible**
- **Failure to give at least 24 hours notice of any needed changes or failure to show up to your visit will result in a broken appointment fee of $50 per hour scheduled**
- **Any broken appointment fee must be paid in full before you will be able to schedule another reserved time**
- **Patients who repeatedly do not appear at scheduled visits will be released as patients and will no longer be able to schedule appointments**

Payment and Insurance Info: We accept payment in cash, checks, and credit card charges. Financing is offered through CARE CREDIT Financial Services who offer interest free payment plans. We work to find a way to make dental treatment affordable to you and your budget.

We realize that understanding your dental insurance can be challenging and do our very best to verify eligibility and coverage for dental benefits. **Unfortunately, detailed information is often withheld from us by your insurance company and benefits are never guaranteed until a claim is received and processed.** We encourage you to familiarize

Please Initial

yourself with your policy and its exclusions, deductibles, frequencies, limitations, and required out of pocket expenses.

We will **estimate** your patient portion prior to any treatment based on the information obtained from your insurance company. Please understand that after processing your claim there may be a balance remaining on your account which you are responsible for. If you have a secondary insurance, as a courtesy, we will submit the claim to them. Please be aware that there may still be a balance after secondary insurance processes the claim.

Fluoride and Sealants for the Whole Family: We openly recommend fluoride and sealants to all patients if appropriate. **These treatments are the least expensive and most effective way for us to help you avoid dental cavities throughout your life.** Insurances choose to cover these treatments for younger patients in most cases. We will confirm coverage for you and inform you during your visits when treatment is recommended. Regardless of insurance coverage, we feel that the benefits of these treatments far exceed the costs in every circumstance.

Records: In the course of providing dental care, we take/record models, videos, pictures, X-rays, audio and any other diagnostic aid to help us in communicating and training our team. It is necessary for us to use these records in order to communicate with each other, with other dental professionals, and often with medical doctors as well. By signing this form, you acknowledge and give Cherrington Dental the right to take, own, and use these records in a manner deemed appropriate by the doctor. These records belong to our office and will be used and discarded as needed. You may receive a copy of any of these records if you simply inform us of that desire.

Metal Free Restorations: Our top concern is to treat you with the most advanced materials, techniques, and services available to improve the cosmetic and functional outcome of treatment. We avoid the use of mercury fillings and the use of metals in all cases if possible. Because we do this in your best interest, some of the procedures we provide are above and beyond what your insurance considers standard. This can generate additional cost to you above the standard fees agreed upon by insurance. We will inform you of this as best as possible when we know it will happen. Again, we desire to give you the best. Insurance in some cases does not share that desire.

Guarantee: Expect a higher standard of care when you see our team. We know that dental care can be stressful for people. We are grateful for you and stand behind our work. The following details summarize our guarantee for our patients:

Please Initial

Our Part:

- We will replace any Ceramic restoration (crowns, veneers, onlays, or inlays) we have placed which develop a structural problem at no charge for 5 years.
- We will replace any filling or sealant we have placed which develops a structural problem at no charge for 1 year.

Your Part: The following conditions are required for the guarantee:

- You must have check-ups with X-rays and cleanings every 6 months (unless instructed to come in more frequently).
- Pay for all dental work we have performed including any amount that insurance does not cover.
- The restoration is the permanent, appropriate treatment recommended by the doctor.
- Any night guard or clenching/grinding treatment recommendations are followed.

To be clear, we guarantee our restorations, not your teeth. If you develop dental decay around a restoration that is something we cannot control. If your tooth fractures or needs to be removed, if the nerve begins to die and requires root canal treatment, we cannot control those situations. By signing this form you consent and are aware of these details.

Privacy: Your privacy is important to us. We create records and information to provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices details your rights and how we use and protect your information. The following is a summary of that notice:

Your rights include:

- A right to inspect and receive a copy of your treatment information.
- A right to request an amendment to your health information.
- A right to request restrictions on how we use or disclose your health information.
- A right to receive a paper copy of our Notice of Privacy Practices.

As previously stated, we may use your information in order to communicate with insurance and other doctors to provide you with excellent dental care. The use of this information will be limited to professional uses.

Everyone affiliated with Cherrington Dental is bound by our confidentiality requirements as outlined in the Notice of Privacy Practices. Please contact us if you have any questions.

Consent: By signing below, you consent to allow us to treat you as a patient and acknowledge that you have read and understand all of the information presented in this welcome packet.

Signature	**Date**