

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
Email: \_\_\_\_\_ Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_  
Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T  F  S  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Do you have or ever had any of the following? Please check those that apply:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Allergies _____          | <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Prosthetic cardiac valve | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Artificial Joints        | <input type="checkbox"/> Previous endocarditis    | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Sulfa Drugs        |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Epilepsy           |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Cardiac Transplant       | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Rheumatism           | OTHER:                                      |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> _____              |
|   | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Stomach Problems     |   |
|   |   | <input type="checkbox"/> Stroke               |   |

• Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Are you currently taking any medication?  Yes  No

If yes, please list: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_  
Name of person or office referring you to our practice: \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# GENERAL CONSENT FOR TREATMENT

We are required to obtain your consent for contemplated or proposed dental treatment or oral surgery. Please read this form carefully and we encourage you to ask us about anything that you do not understand. We will be glad to explain it to you.

1. I hereby authorize and direct **Spring Cypress Dental**, or any of its subsidiaries, assisted by licensed dentists and/or dental auxiliaries of their choice to perform upon me, or my child (name) \_\_\_\_\_ the following dental treatment or oral surgery procedures including the necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.
2. In general terms, the dental procedures may include one or a number of the Following:
  - Cleaning of the teeth and application of topical fluoride.
  - Application of sealants to the grooves of the teeth.
  - Treatment of diseased or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
  - Stainless steel crowns for children. These are necessary in cases where simple fillings would not be the best long term restoration or in cases where there are large cavities.
  - The replacement of missing teeth with a dental prosthesis (crown, partials, etc.).
  - Extraction (removal) of one or more teeth that cannot be saved.
  - Treatment of diseased or injured oral tissues (hard and/or soft).
  - Treatment of malposed (crooked) teeth and/or developmental abnormalities.
  - Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or (root canal treatment).
  - The use of sedative medications and/or nitrous oxide to control apprehension and/or Disruptive behavior.

The treatment has been explained to me. **I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed.** Alternative methods of treatment, if any have been explained to me, as have the advantages and disadvantages of each. I am advised that good results are expected; however, the possibility and nature of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I further understand and authorize the doctor to perform any necessary treatment that in his/her judgment will be in the best interest of my or my child's health, once treatment has been initiated.

3. Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgery procedures, medication and/or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, and scarring. I understand and accept that complications may require medical assistance, hospitalization and in very rare cases death.

I hereby state that I have read and fully understand this consent. I have been given an opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time that I choose to terminate. Such termination of consent must be in writing.

**PATIENT NAME:** \_\_\_\_\_ **WITNESS:** \_\_\_\_\_

**SIGNATURE OF PATIENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# SPRING CYPRESS DENTAL

Please take a moment to fill this out so we can better treat your needs.

PATIENTS NAME: \_\_\_\_\_

1. What is your main purpose for your visit today?

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2. What would you most like to change about your smile?

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3. If possible, would you like to get started with treatment today?

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4. When was your last dental visit?

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5. When was your last dental cleaning?

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6. Have you ever considered teeth whitening? If not would you like to?

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7. Have you ever had any of the following:

FILLING	VENEER
EXTRACTION	INLAY/ONLAY
ROOT CANAL	CROWN/BRIDGE

8. Do you prefer morning or afternoon appointments?

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8. How did you hear about us?

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**THANK YOU!**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE**

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PLEASE REVIEW THIS ACKNOWLEDGEMENT AND SIGN BELOW AFTER YOU  
HAVE RECEIVED THE INFORMATION THAT HAS BEEN CHECKED ON  
THE LIST SHOWN BELOW:

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**ACKNOWLEDGEMENT:**

\_\_\_\_\_ I acknowledge that I have received and/or read and been offered a copy of the office's NOTICE OF PRIVACY PRACTICES AND RIGHTS. I have read the notice and I understand my privacy rights and the office's privacy policies.

\_\_\_\_\_ Patient refuses to sign the notice. Employee name and date \_\_\_\_\_.

\_\_\_\_\_ The patient is unable to sign the acknowledgement or is a minor. If the patient is a minor or represented by a personal representative, the authorized guardian/representative has signed below.

X \_\_\_\_\_

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PRIVACY OFFICER CONTACT INFORMATION

# OFFICE POLICIES

**We would like to welcome you to Spring Cypress Dental.**

**Our mission is:**

*“To provide the highest quality dental care in the most comfortable environment possible.”*

**Focusing on:**

*“Personal Attention Professional Excellence”*

1. Our office hours are Mon, Wed, Fri 8AM to 5PM and Tues and Thurs 9AM to 6PM. We also offer Saturday appointments (by appointment only). We require a 24 hour notice of either canceling (**CA**) or rescheduling (**RS**) an appointment on any appointment scheduled M-F and a 48 hour notice of canceling or rescheduling for a Saturday. Otherwise there will be a charge assessed for any **CA** or **RS** appointment without proper notice. The charges are as follow: \$30.00 charge per hour for Hygiene (cleanings, recalls) \$50.00 charge per hour for treatment with the doctor.

However, with **extenuating circumstances** there are always exceptions to these charges.

2. As a courtesy, we will call a week in advance for any hygiene appointment (cleanings), as a reminder and a day before to confirm hygiene and any other appointments.
3. We will leave a message on your voicemail regarding any appointment, if we have not spoken to you personally, it is your responsibility to call us back to confirm.
4. If you are going to be late for an appointment, please call us in advance to ensure that your tardiness will not affect patients scheduled after you. Otherwise, we may have to reschedule the appointment for another day or time.
5. If you have dental insurance, we will file the insurance for you. However, when gathering information from your insurance company and going over your treatment plan with you, there is no guarantee what or if the insurance will pay. It is only an **estimate**. We will try to give you as close an estimate as possible. We will allow **60** days for your insurance to pay, however if they have not paid in that time frame we ask that you file or contact the insurance, otherwise any balance remaining will be **your responsibility**, and your insurance can reimburse you directly.
6. Payment is due at the time services are rendered. The methods of payment that are accepted in our office are Cash, Check, Credit Cards (which include, **VISA, MC, AMEX, and DISCOVER**). **Care Credit** is accepted for qualified applicants. We will gladly accept your check, however, there will be a **35.00** return check fee assessed for any check returned for non-sufficient funds from your checking account.
7. If there are any changes in your health history, address, telephone number, marital status, or insurance, we ask that you notify the office as soon as possible, so that we can update your file.

We value you as a patient, and we look forward to caring for your oral healthcare needs and to establishing a long lasting relationship with our doctors and staff.

Thanks for choosing **Spring Cypress Dental!**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_