HOBBLE CREEK DENTAL CARE

Stephen W. Pratt, DDS

Thank you for selecting us to provide for your oral health needs. We promise our best in providing you with Excellence, Value, and Care in dentistry and hope to become an office that you love and will refer your family and friends to.

Patient Information

Full Name:_____ Preferred Name:_____

Date of Birth:_____ Male___ Female___ Social Security#:_____ ***(*Required for HIPPA)***

Employer:_____ Work Phone#: _____

Cell Phone#: _____ Email:_____

Would you like to receive appointment reminders by text and/or email? Yes _____ No_____

Married___ Single___ Child___ Widowed___ Divorced ___

Referral Source: *(who can we thank for bringing you here?)*_____

Household Information *(You only need to complete this section once per family)*

Home Address: _____

City:_____ State:_____ Zip code:_____ Home Phone#: _____

Responsible party: _____

Dental Insurance Information *(Make sure we make a copy of your **primary** and **secondary insurance** cards)*

Primary Dental Carrier

Subscriber Name_____ Subscriber ID #_____ Subscriber DOB_____

Insurance Co._____ Group #_____

Employer _____ Relation to patient_____

Secondary Dental Carrier

Subscriber Name_____ Subscriber ID #_____ Subscriber DOB_____

Insurance Co._____ Group #_____

Employer_____ Relation to patient_____

Office Policies

Privacy Policy: We are committed to keeping all of your information private and will not discuss or share personal information except with those authorized by you. We shred and properly dispose of all documents that have any personal information on them. Your email is kept private. We fully comply with all provisions of HIPAA *(Health Insurance Portability & Accountability Act of 1996)*. We commit to informing you about all procedures. We encourage you to diligently ask us if you have any questions about any procedures or their necessity, for we want you completely comfortable throughout the entire process.

Payment Policy

· You agree to be responsible for payment of your own dental bill. We will do our best to help bill your insurance, but you are responsible if they do not cover services performed.

· **All copayments** *(or entire fee for customers without insurance)* **are due the day of your appointment.**

· We accept cash, checks, and credit cards.

· We offer **0% interest for up to 6 months** financing through **Care Credit.**

· **We charge $50 for all missed appointments without 24 hour cancellation notice, or if your appointment is canceled at the time of service because of your inability to pay or arrange financing.**

Signature:_____ **Date:**_____ **Relationship to Patient:**_____

Health History

Patient Name: _____ Physician's name:_____ Physician's Phone:_____

Yes/ No

___ ___1. Have you been under a physician's care or had any health problems in recent years?
If yes, please explain:_____
_____

___ ___2. Please list **name** and **purpose** of any **medications** you currently take: _____
_____
_____
_____

___ ___3. Are you currently taking a blood thinner? (type) _____

___ ___4. Do you require antibiotic premedication? (why/when?)_____

___ ___5. Please circle any **allergies:** Latex Penicillin Other Antibiotics Sulfa Drug Local Anesthetic
Other (*explain*)_____

___ ___6. (*Women only*) Are you pregnant, trying to get pregnant, or nursing? (*Which/Due Date?*)_____

___ ___7. Do you have a history of gum disease?

When was your last dental visit?_____ Dentist's name _____

Do you have or have you ever had any of the following? (Please check "no" if it doesn't apply)

Yes/No
___ ___Abnormal Bleeding
___ ___Alcohol Abuse
___ ___Allergies
___ ___Anemia
___ ___Angina/Chest Pain
___ ___Arthritis
___ ___Asthma
(*last attack?*)_____
___ ___Blood Transfusion
(*when?*)_____
___ ___Cancer
(*type?*)_____
___ ___Chemotherapy
___ ___Colitis
___ ___Congenital Heart Defect
(*type?*)_____
___ ___Diabetes (*type?*)_____
___ ___Difficulty Breathing
___ ___Drug Abuse
___ ___Emphysema
___ ___Epilepsy

Yes/No
___ ___Facial Surgery
___ ___Fainting Spells
___ ___Fever Blisters
___ ___Frequent Headaches
___ ___Glaucoma
___ ___HIV or AIDS
___ ___Heart Attack
(*when?*)_____
___ ___Heart Conditions
(*when/type?*)_____
___ ___Heart Murmur
___ ___Heart Surgery
(*when/type?*)_____
___ ___Hemophilia
___ ___Hepatitis A, B, or C
(*type*)_____
___ ___High Blood Pressure
___ ___Joint Replacement
(*where/when?*)_____
___ ___Kidney Problems
___ ___Liver Disease

Yes/No
___ ___Osteoporosis
___ ___Pace Maker
___ ___Psychiatric Problems
___ ___Radiation Therapy
(*when?*)_____
___ ___Rheumatic Fever
___ ___Seizures
(*most recent?*)_____
___ ___Sexually Transmitted Disease
___ ___Sickle Cell Disease
___ ___Sinus Problems
___ ___Sleep problems (Apnea)
___ ___Stroke
(*when?*)_____
___ ___Tobacco Use
___ ___Thyroid Problems
___ ___Tuberculosis
___ ___Ulcers
___ ___Do you require Antibiotic Premedication?
___ ___Other _____

I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following surgery or tooth extractions.

I hereby certify that my answers to the forgoing questions are accurate. Since a change in my medical conditions or medications can affect dental treatment, I agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature_____ **Date** _____
(Patient, legal guardian or authorized agent of patient)

Office Financial Policies and Federal Truth-in-Lending Statement

The best dental care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our billing team.

Insurance Counseling/Billing

It is your responsibility to provide us with information regarding your insurance carrier and a copy of your insurance card(s). Before any procedure is performed in which you may incur expenses; our billing team will call your insurance to determine your benefits. I understand that Hobble Creek Dental Care will provide me with an **estimate**, and inform me of fees that may be my responsibility. I understand that Hobble Creek Dental Care will contact my insurance company on my behalf to assist me in the payment of my claims. They will prepare the dental insurance forms, follow up on un-received payments, and collect payment from my insurance company toward my account. I understand that this office cannot render services on the assumption that charges will be paid in full by my insurance company. I also understand that I am personally responsible for payment of all dental services that are not covered by insurance.

Patient Billing Without Insurance – "Self-Pay"

Hobble Creek Dental Care will provide a clear treatment plan with associated cost estimates before any work begins. I understand that I am expected to pay the full quoted fee on the day the service is performed. I understand that the in-house discount plan is optional and **NOT** an insurance plan. The plan allows me to keep up on my oral health by providing me a discount on bi-annual cleanings, exams, and x-rays and saving me 25% on any future dental work (excluding orthodontics).

Payment Policy

We collect all copays, deductibles and fees for service on the same day that your dental service is performed (including emergencies). *An additional $10.00 will be added to your bill if you do not pay your co-pay on the day of service to cover the additional billing expenses incurred. If your financial circumstance warrants an extended payment plan, our billing team is happy to give you information for finance options with Care Credit. Any financial arrangements must be made in advance. Treatment plan estimates can change and prices will only be honored for a period of six months from the date of your examination.

Late Fees & Collections

A late charge of $25.00 will be assessed on all outstanding balances exceeding the thirty day grace period unless previously written financial arrangements with a secured credit/debit card on file. Additional $25.00 late fees will follow if account balance exceeds 60 days

If circumstances arise that I neglect my responsibilities of payment, my account will be assigned to a collection agency in which I agree to pay, the outstanding balance plus a collection agency commission of 40%. Further action may result in attorney fees and court costs in accordance with Utah Code Annotated, sec12-1-11. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary. I understand at which time all communication regarding my account must be directed to the collection agency/attorney and not through Hobble Creek Dental Care.

Lab Fees

In the event that my treatment requires a third-party laboratory for procedures I will agree to pay for half of my procedure on the preparation date. The final payment is due on the delivery date. I also understand that if for any reason I cannot complete my treatment I will still be held accountable for all lab fees and doctor's "prep" time incurred.

Guarantee

Dr. Stephen Pratt and associates pride their services on the use of quality, tested materials and technology to provide outstanding dental treatment. In the event that dental work fails due to materials or provider error we will gladly stand behind our work and replace any procedure within the standard insurance time table guidelines (Fillings: 2 years. Crowns: 5 years). **However, I understand that poor oral hygiene is a factor in the breakdown of my dental work and decay will shorten the expectancy. I understand that I will forfeit the guarantee if I do not stay current on my 6 month checkups or if the work fails due to decay from poor home care.**

I grant permission to be contacted by telephone (at home, cell, text, or work place) to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my machine or with a family member. This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void. I acknowledge that I have access to a copy of Hobble Creek Dental Care's Privacy Policies, and can obtain a personal copy upon request. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I hereby agree to abide by the conditions outlined hereon.

Signature of patient, parent or guardian	**Date**	**Relationship to patient**

CONSENT TO PROCEED

I authorize Dr. Stephen Pratt, and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesics, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as a part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with standard dental preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____
(Please Print)

Signature:_____ **Date:**_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ **Date:** _____