

Patient Information	
PATIENT'S NAME _____ <small>First MI Last</small>	Birth Date _____
Married <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>	
Address _____ <small>City/State/Zip</small>	
Telephone (home) _____ (work) _____ (cell) _____	
SS# _____ Email address _____	
Employer _____ Occupation _____	

Initial here if the responsible party is the same as above _____

Responsible Party Information	
NAME _____ <small>First MI Last</small>	Birth Date _____
Address _____ <small>Street City State Zip</small>	
Telephone (home) _____ (work) _____ (cell) _____	
Employer _____ Occupation _____	
Relationship to Patient _____ Social Security # _____	

Responsible Party's Spouse	
NAME _____ <small>First MI Last</small>	Birth Date _____
Address (if different from above) _____ <small>Street City State Zip</small>	
Telephone (home) _____ (work) _____ (cell) _____	
Employer _____ Occupation _____	

Emergency Contact (Relative not living with you)	
Name: _____	Relationship _____
Address: _____ <small>Street City State Zip</small>	Phone _____

Whom may we thank for referring you to our office? _____

Method of Payment (Please check one)

Payment in full at each appointment for my estimated portions. (cash, check, Visa, Master Card, American Express, or Discover).

I would like to hear about your finance options through Chase Health Advance and Care Credit.

I certify that this information is true. I will notify you of any changes. I understand there is a \$50 per hour fee for a missed or canceled appointment without a notice of 2 business days.

Print patient name _____

Signed _____ Date _____

Financial Policies

Copper Ridge Dental accepts several forms of payment for dental treatment provided at this office: *Cash, debit card, personal check, credit card* (MasterCard, Visa, Discover, American Express).

Financing Options: We offer convenient monthly payment plans through Care Credit. This third party financial group offers six and twelve month payment plans with no interest. The application is simple and can be completed online, over the phone, or in the office.

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to provide reasonable assistance to help you maximize your benefits. Most dental insurance excludes coverage for some services, uses restricted fee schedules for most services, and can decline payment based on any number of policy restrictions and limitations. All such restrictions and limitations are based on the premium paid by your employer for the coverage, *not* on our fees or the treatment we recommend. We encourage you to become familiar with your policy: its coverage, exclusions, deductibles and maximums. *We will recommend treatment appropriate to your dental needs regardless of your insurance coverage.*

Our courtesy service to our insured patients includes:

- 1) Filing your claims promptly and requesting that payment be sent directly to us.
- 2) Following American Dental Association guidelines for claims coding and filing.
- 3) Estimating your benefits to the best of our ability. Most insurance companies will *not* provide us with detailed information about your coverage, so any insurance figures we provide you are only estimates!

Our expectations of you as the insured patient and/or owner of the policy:

- 1) You will pay, at the time of service, your fees estimated not to be covered by your insurance (co-payment).
- 2) You will assume responsibility for any amounts expected from your insurance company but not received within 60 days after treatment has been performed and the claim submitted. Please understand that the insurance policy belongs to *you* and we have no leverage to obtain payment from your insurance company.

I hereby authorize Copper Ridge Dental to release to my insurance company any information acquired in the course of my dental care. I authorize benefits to be paid directly to Dr. Erik Cantwell. I understand I am responsible for all fees incurred, **regardless of insurance involvement**. I understand that treatment cannot be completed until it is paid for (e.g., crowns will not be cemented, dentures will not be placed). In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I understand that interest charges of 1.5% per month (18% annually) will accrue on balances older than 60 days. 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.

The following family members are covered by this agreement:

Responsible Party: _____

Signature

Date

**HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT
AND CONSENT TO PROCEED**

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Erik Cantwell and/or such associates or assistants as 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), analgesic, 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, temporary or, rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possible quite painful both during and/or after completion of treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive 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 give the opportunity to ask questions.

SIGNATURE _____

DATE: _____

WITNESS _____

DATE: _____

PATIENT NAME: _____ DATE: _____

Medical History

Please Circle

Have you been a patient in the hospital during the past two years? YES NO
Have you been under the care of a medical doctor during the past two years? YES NO

If yes, list the condition(s) being treated: _____

Have you taken any medicine or drugs during the past two years? YES NO

If yes, list them: _____

Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications, or contact to metals? YES NO

If yes, list them: _____

Have you ever had any excessive bleeding requiring special treatment? YES NO

Do you smoke or use tobacco in any form? YES NO

Are you presently taking Coumadin, Heparin, or any other blood thinner? YES NO

Do you now have, or have you ever had any of the following? Please check the appropriate boxes.

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C (serum)	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Allergy or Hives
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint (Knee, Hip,etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (Cancer, Leukemia)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells			
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	X-ray or Cobalt Treatment
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder

Have you received I.V. bisphosphonate therapy (Zometa, Aredia, Boniva) or are you taking oral bisphosphonates (Fosamax, Actonel, Skelid)? YES NO

Have you ever used Phen-Fen or other appetite suppression combinations for weight loss? YES NO

If you have taken Phen-Fen or other appetite suppression combinations, have you been evaluated by your physician or cardiologist or have you under gone an echocardiogram? YES NO

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO

Do your ankles swell during the day? YES NO

Do you ever wake up from sleep short of breath? YES NO

Do you have any difficulty breathing? YES NO

Have you lost or gained more than 10 pounds in the past year? YES NO

Are you on a special diet? YES NO

Has your medical doctor ever said you have a cancer or tumor? YES NO

Do you have any disease, condition, or problem not listed? YES NO
If yes, list: _____

Women:

Are you pregnant now? YES NO

Are you taking birth control pills? YES NO

Do you anticipate becoming pregnant? YES NO

Have you had surgical breast implants? YES NO

Have you been diagnosed with human papillomavirus (HPV) YES NO

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any change in this health information or medications at any subsequent appointment.

X _____ Date _____
SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN

Reviewed by Doctor/Hygienist _____ Date _____

Don't Wait Until It Hurts

Periodontal disease is painless. It affects 75% of the population and often victims are unaware.

It may also affect your overall health. There are warning signs and the American Dental Association and our staff want you to be aware.

- Do your gums bleed when you brush your teeth or toothpick between them? Yes No
- Are your gums red, swollen, or tender? Yes No
- Are your gums pulling away from your teeth? Yes No
- Do you see pus between your teeth and your gums when the gums are pressed? Yes No
- Are your permanent teeth loose and separating? Yes No
- Is there any change in the way your teeth fit together when you bite? Yes No
- Is there any change in the fit of your partial dentures? Yes No
- Do you have persistent bad breath? Yes No

If the answer is yes to any of these questions, bring it to the attention of your dentist or hygienist.

Copper Ridge Dental
(801) 260-0530

Act now and keep your teeth for a lifetime

INSURANCE

IT IS YOUR RESPONSIBILITY TO KNOW HOW IT WORKS

As a courtesy we will submit your insurance claim for you.

If we file your insurance claim and they deny payment due to waiting periods, frequencies, or plan limitations, payment is due from you. In an effort to COLLECT payment from your insurance we need all information to be current and accurate. Please inform us of any changes with your insurance as soon as you are aware of them.

We will estimate your co pay to the best of our ability. This will be due at the time of service. Remember, this is just an estimate. Any balance unpaid is your responsibility.

SECONDARY INSURANCE

Ideally, having two insurance carriers leaves the patient with little or no out of pocket expense. However, some insurance companies do coordinate benefits.

If your secondary insurance denies or fails to pay a claim, your payment is due immediately.

POLICY HOLDER _____
EMPLOYER _____
SOCIAL OR I.D.# _____
PRIMARY INSURANCE COMPANY _____
CLAIMS ADDRESS _____
PHONE # _____

POLICY HOLDER _____
EMPLOYER _____
SOCIAL OR I.D.# _____
SECONDARY INSURANCE COMPANY _____
CLAIMS ADDRESS _____
PHONE # _____

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have reviewed Copper Ridge Dental's policy concerning insurance.

Print Patient Name: _____

Signature: _____ Date: _____

Dr. Erik Cantwell

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have reviewed a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature (Patient, Parent or Guardian)

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-