Rocky View Family Dental & Implant Center
New Patient Information - 2022

Name: ____ **Date**: _________________________

Date of Birth: _________________ **Patient or Guardian SSN**:_______________________

Address: ____
(street) (apt/unit#)

________________________,_____________________________________
(city) (state) (zip)

Email: ____

Cell Phone: _(_________)____________________

Home Phone: _(_________)___________________ **Work Phone**: _(_________)______________

Insurance Information:

Insurance Company: ___________________________

Primary Subscriber's Name: ____________________________ **Relationship:** _____________

Primary Subscribers Date of Birth: ___________________

Group Name (Employer): _______________________________________**Group #:** ___________

Member ID#:_________________________ **Subscriber's SSN**: ________________________

Insurance Company Phone Number: _(___________)_________________________________

Insurance Company Claims Mailing Address: _______________________________________

Emergency Information:

Contact Name: ______________________________ Relationship: ______________________

Phone number: (__________)_________________________

Physician / Practice name: ____

Phone number: _(__________)________________________

Referral Information:

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

Medical Alerts:

Y N
| | | | Allergy-Aspirin
| | | | Allergy-Clindamycin
| | | | Allergy-Codeine
| | | | Allergy-Erythromycin
| | | | Allergy-Latex
| | | | Allergy-Local Anesthetics
| | | | Allergy-Nitrous Oxide
| | | | Allergy-Penicillin
| | | | Allergies-Other or Medications____________________________
| | | | Anaphylaxis
| | | | Artificial Joints
| | | | Asthma
| | | | Blood Thinners
| | | | Cancer Treatment
| | | | Diabetes (insulin dependent? Y__ N__)
| | | | Drug / Alcohol Addiction
| | | | Epilepsy / Seizures
| | | | Glaucoma
| | | | Heart-Mitral Valve Prolapse
| | | | Heart Problems (Have you ever taken Fen-Phen/Redux? Y / N)
| | | | Heart Murmur
| | | | Heart Valve Replacement
| | | | Hemophilia
| | | | Hepatitis B
| | | | Hepatitis C
| | | | High Blood Pressure
| | | | HIV / AIDS
| | | | Multiple Sclerosis
| | | | Pre-medicate for dental appt
| | | | Pacemaker
| | | | Psychiatric Care
| | | | Radiation Treatment
| | | | Stroke
| | | | Ulcer / Colitis
| | | | Other ____

List any **medications/herbs/vitamins** you are currently taking?
____
____

Do you have a family history of Heart Disease, Stroke, Diabetes, or Gum Disease? (please circle)

Dental History:

Previous Dentist: ____

Reason for leaving: ____

When was your last dental **cleaning**?:_____________________

When was your last dental **exam** performed by the dentist?: ____________________

When were your last dental **x-rays** taken?: _______________________

Do you have any problems with your gums(i.e. bleeding or swelling) A LOT / A LITTLE / NONE_
(please circle)

Do you have any fears about receiving dental treatment? A LOT / A LITTLE / NONE_

Would you be interested in being sedated for your treatment? _Y / N / Maybe

Are you happy with your smile? _Y / N_

Do you smoke or use smokeless tobacco?_Y / N_ If yes, how often?_____________________

Patient Acknowledgement of Privacy Policy (HIPAA)

I, _____________________________________, acknowledge that I have received or reviewed
(print name)
the Office Privacy Policy Notice for Rocky View Dental Care, P.C.

Signature ____ Date ______________
Patient/Legal Guardian

Should you choose to decline to sign the acknowledgement, we are required to indicate your reason(s) for refusal.

Patient Acknowledgement of Medical Information

I certify that everything stated regarding my health and dental history is correct to the best of my knowledge.

Signature____ Date ______________
Patient/Legal Guardian

Consent For Treatment

The Undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk.

Signature____Date_______________
Patient/Legal Guardian

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Financial Responsibility

I understand that Rocky View Family Dental Care and Implant Center requires **payment due in full at the time of service.** For treatment requiring multiple appointments, alternative payment arrangements may be provided. Rocky View Family Dental and Implant Center is happy to work with my insurance carrier in order to maximize benefits and directly bill them for reimbursement of treatment. However, if payment from the insurance carrier is not received within 90 days of the services, I understand I will be responsible for payment of my treatment fees and collection of my benefits directly from my insurance carrier. I understand there will be a monthly 2% interest fee ($5.00 minimum) for balances over 90 days past-due. A fee of $75.00 is charged for patients who miss or cancel an appointment without 48-hour notice per hour scheduled. Rocky View Family Dental and Implant Center charges $30 for returned checks. If a payment plan has been arranged and payments are not made as scheduled, there will be a $30 Declined Credit Card fee each month that the card on file declines. I further agree that should unpaid monies remain owed, I am responsible for all collections fees and/or attorney fees incurred in the process of collecting the unpaid balance, not limited to allowable interest, but also any court costs as well.

Signature____Date_________________
Patient/Legal Guardian

Missed Appointment Policy

Our missed appointment policy enables us to maintain appointment time for all patients who are in need of dental treatment. This enables us to keep your cost of dental care down. The following is our office policy.

- A missed appointment is when you fail to show up for an appointment without a notification at least 24 hour notice.
- **One** missed appointment **-** You will receive a letter informing you of the missed appointment and will be offered the opportunity to reschedule.
- **Two** missed appointments within a 12 month period – You will receive a letter informing you of the two missed appointments and you will be charged a $50.00 Missed Appointment fee per hour scheduled. *(*Please note, if your appointment is 3 or more hours in length, you will be charged $75.00 per hour.)*
- **Three** missed appointments within a 12 month period – You will receive a letter informing you of the three missed appointments, charged a $50.00 missed appointment fee per hour missed and you may be dismissed as a patient from the practice.

We are understanding of unforeseen circumstances and all we ask is that you please contact our office with as much notice as possible if you do need to reschedule your appointment. Thank you.

I have read and understand the above mentioned policies.

Patient name: ____

Patient Signature: ____

Date: ____

We are understanding of unforeseen circumstances and all we ask is that you please contact our office with as much notice as possible if you do need to reschedule your appointment. Thank you.