**SILVER CREEK FAMILY DENTAL**

|  |  |  |
| --- | --- | --- |
| NAME (*Last, First, Middle Initial*) | HOW DID YOU HEAR ABOUT US? | BIRTHDATE |
| AGE |
| MAILING ADDRESS | HOME PHONE | MOBILE (*optional*) |
| PHYSICAL ADDRESS (*if different*) | E-MAIL ADDRESS *(please provide if you would like checkup reminders by e-mail*) |

**SECTION 1- Patient Information**

**SECTION 2- Account Information**

Who is financially responsible for this patient? *Check one:*

*□* Self: Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*□* Parent/Guardian/Other:

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mailing Address (*if different than patient address*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION 3- Insurance Information (*If Applicable*)**

Dental Plan Name (Delta Dental, MetLife, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is insurance through an employer? *□*No*□*Yes Group# (*if known*):\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who in your family is the subscriber (primary person) on the insurance plan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION 4**- **Acknowledgement of Receipt of Silver Creek Family Dental Privacy Policies**

I, the undersigned, have **received** a copy of this office's Privacy Policies.

Signature of Patient/Patient Representative Date

Name of Patient/Representative (Please Print Legibly) Relationship to Patient (if other than self)

**CONSENT TO PROCEED**

 I authorize Dr. Russell A. Smith 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, 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 preventive 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. Holding one’s mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also 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 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 or death, 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 given the opportunity to ask questions.

 I understand that I am responsible for the estimated total patient payment at the time services are rendered. I understand that if I elect to use dental insurance, the insurance company may ultimately deny payment for all or part of my dental services. It will then be my responsibility to pay any outstanding balance.

 I understand that Silver Creek Family Dental can't extend patient credit. Outstanding balances will be charged 2% monthly interest or $10.00 per month, whichever is greater. Unpaid balances will be turned over to a collections agency after 3 months. If I have financial concerns, I will bring them up prior to scheduling treatment.

 I understand that scheduling an appointment reserves the time of the doctor, staff, and the dental operatory for me. If I cannot keep my appointment, I will call no less than 24 hours prior to my appointment time to cancel. Otherwise I will be charged for the appointment, which could have been used by another patient in need of treatment. This consent lasts until terminated in writing.

Patient Name:

Signature: Date:

 (Patient, legal guardian or authorized agent of patient)

Witness: Date: