RIVERTON DENTAL

Jeffrey T. Pearson, DMD

Patient Information

Patient Name: _____ M◯F◯

Date of Birth: ____/____/____ SS#: _____ This will be collected in office

Address:

_____
Street Apt #

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

If Patient is a Minor

Guardians Name: _____

Address: _____

Home #: _____ Cell #: _____

Email: _____

In the event of emergency: (Friend or Relative not living with you)

Emergency Contact: _____ #: _____

Relationship to patient: _____

Whom may we thank for referring you? _____

Dental Insurance

Primary Dental Insurance: _____

Phone #: _____ Plan Type: PPO◯HMO◯

Address: _____

Member #: _____ Group #: _____

Insured Name: _____ SS#: _____ This will be collected in office

Insured Birth Date: _____ Relation: _____

Secondary Dental Insurance: _____

Phone #: _____ Plan Type: PPO◯HMO◯

Address: _____

Member #: _____ Group #: _____

Insured Name: _____ SS#: _____ This will be collected in office

Insured Birth Date: _____ Relation: _____

Person Responsible for Dental Investment:

_____

Are you concerned with the finances required to return your teeth to excellent health?

□ Yes □ No

Riverton Dental Acknowledgement of Notice of Privacy Practice and Communication Agreement

I, _____, have been given the chance to receive and review a copy of the office's Notice of Privacy Practices. I, _____, agree that Riverton Dental may communicate with me electronically through my email address and cell phone number.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address. I understand that I can withdraw my consent to electronic communications at any time.

Patient Signature: _____ Date: _____

* You may refuse to sign this acknowledgement

Dental History

Yes No

- ○ ○ Are your teeth sensitive to hot, cold, or biting pressure? (circle which one)
- ○ ○ Does food/floss abnormally catch between your teeth?
- ○ ○ Do your gums bleed when you brush/floss?
- ○ ○ Have you previously been treated for or diagnosed with periodontal disease?
- ○ ○ Do you have any problems of the Jaw?
  - ☐ Popping/Clicking ☐ Pain ☐ Difficulty Opening/Closing ☐ Difficulty Chewing
- ○ ○ Are you dissatisfied with your teeth and their appearance?
  - If yes, explain: _____
- ○ ○ Do you smoke?
- ○ ○ Do you have any dental related fears?
  - If yes, Explain: _____

When was your last Dental Appointment? _____

Medical History

TO THE BEST OF YOUR KNOWLEDGE HAVE YOU EVER BEEN AFFLICTED WITH:

- ☐ ANEMIA / SICKLE CELL ANEMIA
- ☐ ASTHMA, EMPHYSEMA, COUGH
- ☐ ARTHRITIS
- ☐ BLOOD TRANSFUSION
- ☐ CANCER OR TUMOR
- ☐ CHEMOTHERAPY
- ☐ DIABETES: TYPE I OR TYPE II
- ☐ HERPES / COLD SORES
- ☐ GLAUCOMA
- ☐ EPILEPSY
- ☐ FAINTING TENDENCY
- ☐ HEART AILMENT
- ☐ HIGH / LOW BLOOD PRESSURE
- ☐ HIV OR AIDS
- ☐ IMPLANTS / ARTIFICIAL JOINTS
- ☐ JAUNDICE, HEPATITIS
- ☐ KIDNEY PROBLEMS
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ PSYCHIATRIC CARE (Anxiety/Depression/Bipolar)
- ☐ RADIATION TREATMENT
- ☐ SHORTNESS OF BREATH
- ☐ SNORING/SLEEP APNEA
- ☐ SINUS/ALLERGIES
- ☐ STOMACH ULCERS
- ☐ STROKE
- ☐ THYROID DISEASE
- ☐ VENEREAL DISEASE
- ☐ TUBERCULOSIS

ARE YOU ALLERGIC OR HAVE HAD A BAD REACTION TO:

- ☐ LOCAL ANESTHETICS
- ☐ SULFA DRUGS
- ☐ CODEINE
- ☐ LATEX
- ☐ PENICILLIN / AMOXICILLIN
- ☐ ASPIRIN
- ☐ METALS
- ☐ OTHER

- Are there any medical conditions not listed above we should know about? _____
- Are you currently under a physician's care now? ○ Yes ○ No What for? _____
- Have you had any serious illness, operations, or hospitalization? ☐ Yes ☐ No
  - If Yes, Explain: _____
- Have you been or are you currently taking Bisphosphonates such as Fosamax, Boniva, Actonel, etc? ☐ Yes ☐ No
- Are you currently taking any medications? ☐ Yes ☐ No if yes, please list them:
  - _____
- Have you previously been diagnosed with Sleep Apnea or currently use a C-PAP Machine? ☐ Yes ☐ No
- WOMEN: Are you currently: ☐ Taking Birth Control ☐ Breast Feeding ☐ Are you Pregnant or trying?

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature: _____ Date: _____

CONSENT TO TREAT

I authorize Dr. Jeffrey Pearson, DMD 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 unwanted 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. 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. 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 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 Fosanax, Boniva, Actonel, may result in complications of non-healing of the jawbones 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 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 treatment has the possibility to change during the appointment time. If treatment changes for me and/or any minor or other individual for which I have responsibility, Riverton Dental will make reasonable effort to contact me to inform me of the changes. I have the option to accept or reject treatment at that time. If I am not reachable, I authorize Riverton Dental to proceed with treatment and I take full financial accountability for that decision.

I also acknowledge that all of the preceding answers and information provided on all forms filled out are true and correct. If I ever have any change in my health or there are changes in my child's health, I will inform Riverton Dental at the next appointment without fail. If changes are not reported, I agree that any damage incurred will be my sole responsibility, financially, and legally.

I acknowledge that I have the right to refuse treatment at which time I must sign the proper refusal forms. I agree that I will be responsible for any damage incurred if prescribed treatment is not rendered within the reasonable prescribed amount of time.

_____

Patient's Name (please print)

_____

Signature of Patient, Parent or Guardian (Print name if you're not the patient) Date

OFFICE FINANCIAL POLICY AND TRUTH IN LENDING STATEMENT

Riverton Dental is happy you have chosen us as your dental provider. We accept a variety of different insurances as a way to benefit our patients. As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services rendered may be charged directly to the patient and that he or she is personally responsible for payment of all services. As a courtesy, Riverton Dental is happy to submit insurance forms to the insurance company designated. We will also be happy to assist you with outstanding claims that need to be resolved. However, we are not the insurance company, and we cannot make the insurance company render payment for services. We will credit all collections received to the patients account. You must understand that most insurance companies will not pay in full for all services rendered, therefore giving the patient a portion due at time of service.

In consideration for the professional services rendered to me, or at my request for my minor child or ward, by the dentist, I agree to pay the reasonable value of services rendered to Riverton Dental at the time services are accomplished. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY.** Riverton Dental cannot render services on the assumption that the charges will be paid in full by an insurance company. I agree that if payment cannot be made at time of service, treatment may be denied and I am responsible for any damage incurred. I agree that any verbal agreement for payment is a legal agreement and I will be held to such agreement until the balance of my account is paid off.

A finance charge of 2.33% (28% per annum) on the unpaid balance will be assessed on all accounts exceeding thirty (30) days from the date of service, unless previous arrangements are satisfied. **I understand that the fee estimate listed for dental services prescribed can only be extended for a period of thirty (30) days, and is an estimate only.** After that period fees and treatments are subject to change at the discretion of the dentist or your insurance carrier.

Riverton Dental offers many financing options. I understand that one will need to be agreed upon prior to appointment date and time. Those financial options are:

1. Cash or Check
2. We accept the following Credit Cards: Visa MasterCard Discover
3. Third Party financing. There are different options available. Please speak with our financial Coordinator to find out more.

Once all insurance claims are received by Riverton Dental from my carrier(s), I understand that I have 90 days to render payment in **FULL** otherwise my account will be sent to a collections agency of Riverton Dental's choice. **Should collections become necessary, the responsible party agrees to pay a collection fee of 40% and all legal fees of collection, with or without suit, including attorney fees and court costs.**

I grant my permission to Riverton Dental to contact me at my home or place of business to discuss matters related to this form. I also agree to let this office leave messages concerning appointments on my answering machine or with family members.

I authorize release of all identifiable information concerning my account, including charges billed, payments made, and interest charges assessed etc. to Riverton Dental and any collections agency this practice decides to use. I authorize release of information to insurance carriers to collect on my behalf. I authorize payment to come directly Riverton Dental.

I understand that there will be a $25 charge + any fee the bank charges Riverton Dental on all returned checks. I understand that after one returned check; the only acceptable method of payment is cash or credit.

I understand that **48 BUSINESS HOUR NOTICE IS REQUIRED FOR CANCELLING APPOINTMENTS (EXCLUDES SATURDAY AND SUNDAY). WE DO NOT ACCEPT CANCELLATIONS VIA TEXT OR EMAIL. A $50 CHARGE PER SCHEDULED HOUR** will be made for broken or failed appointments. In order to keep costs low, I agree that I must be at each appointment as agreed and scheduled whether or not Riverton Dental is able to reach me. 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 is null and void. I hereby agree to abide by the conditions outlined herein.

_____

Name (Please Print)

_____

Signature of Patient, Parent or Guardian (Print your name if you are not the patient) Date

CLEAR FORMS