



SHOAL CREEK
DENTAL CARE

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: Email Address:

Phone: Best time to call:
Home Work Ext Mobile

Address:
Street Address

City State Zip Code

Preferred Appointment Times:

Monday Tuesday Wednesday Thursday
 Morning Afternoon Any Time

Whom may we thank for referring you to our practice?

Yellow Pages Internet Newspaper
 School Work Insurance
 Sign Patient (name below) Other (name below):

Name of person, office or other source referring you to our practice:



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Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: Email Address:

Phone: Best time to call:
Home Work Ext Mobile

Address:
Street Address

City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: Phone:

Address:
Street Address

City State Zip Code



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Dental Insurance Information

Primary Dental Insurance:

Name of Insured:
Last First MI

Insured Birth Date: ID # Group #

Insured Address:
Street Address

City State Zip Code

Insured's Employer Name:

Employer Address:
Street Address

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:
Street Address

City State Zip Code



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Health Information

Chart #: _____ FOR OFFICE USE ONLY

Date of Last Dental Visit: _____ Reason for this Visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> AIDS or HIV+ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Aspirin Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | Due Date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Erythromycin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Jewelry Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Coumadin Patient | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis | _____ |

Have you ever had any complication following dental treatment? Yes No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Are you now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you Currently Use Tobacco: _____

List all medications you are currently taking: _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____



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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I have read and understand the HIPPA policy for Shoal Creek Dental Care.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____

Date: _____

Relationship to Patient:



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OFFICE POLICIES

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our OFFICE POLICIES. If you have any questions, please ask the front desk.

1. **VERIFYING INSURANCE:** As a courtesy to you, we will verify your insurance for eligibility benefits prior to your appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.
2. **PAYMENT:** Payment is due at the time of service. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.
3. **INSURANCE INFORMATION:** New Insurance as well as changes in INSURANCE must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being your responsibility.
4. **CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be kept current with our office.
5. **REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to immediately. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibility.
6. **PAYMENT PLANS:** Our office offers Third Party Financing if needed to assist you in paying for any necessary treatment.
7. **BALANCES:** If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collections agency. If this happens, a collection fee (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.
8. **RETURNED CHECKS:** There will be a \$30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.
9. **CANCELLATIONS / FAILED APPOINTMENTS:** We request 24-hours notice if you are cancelling an appointment. There will be a \$35 fee for cancellations made without 24 hours notice and for failed appointments ("no shows"). The \$35 will be posted to your account, and you will not be allowed to make any other appointments for yourself or your family members until it is paid in full.

*** Thank you for reading this information in full. Please sign below to acknowledge your understanding of the OFFICE POLICIES ***

Patient or Guardian Signature _____ Date _____

Patient Name (Please Print) _____

Shoal Creek Dental Care
8015 Shoal Creek Blvd., Ste. 120
Austin, Texas 78757



(512) 453-8181

www.shoalcreekdental.com
info@shoalcreekdental.com

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Consent for Internet Communications

Patient Name:
Last First MI Preferred Name

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or any other need to deactivate my ID due to security concerns.