Whispering Ridge Family Dentistry
Patient Information

Methods of Payment

Your portion is due on the date service is rendered

1. Cash or Debit/Credit Card is accepted (MasterCard or Visa)
2. Third Party Financing (Care Credit) is accepted if approved by office prior to appointment

Dental Insurance

1. Our office will assist you in obtaining the maximum benefits specified in your contract. **However, your insurance is between you, your employer, and the insurance company.**
2. As a courtesy to you, we will file your insurance and accept assignment of benefits. Our computer system will estimate your portion based on the information you have provided us. **We ask that your estimated co-payment and deductible be paid at the time of service.**
3. **Not all services are a covered benefit in all contracts. Some insurances arbitrarily select certain services they will cover.** With the numerous insurance carriers and policies available, it is impossible to be familiar with the specific treatments covered and the coverage amounts for each. Since you are receiving professional service, you are ultimately responsible for payment whether or not it is a covered item by your insurance.

Related Information

1. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% monthly or 18% annually. Returned checks will be assessed additional fees and will be turned over to a collection agency if not paid in a timely manner.
2. In the event that the account is not paid and we refer the account to a collection agency, you will be responsible for all fees incurred for the collection of your bill.
3. Your appointment time has been reserved exclusively for you. We require 48 business hours for rescheduling of appointments. If you are scheduled following a holiday or weekend, a notice during office hours the week prior is mandatory. In the event that you must break an appointment with less than **48 business hours notice,** we have a **$50 missed appointment fee.**

_____ _____

Signature of Patient/Parent/Legal Guardian Date

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment plan directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound by such restrictions.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

Privacy Authorization

I give permission to Whispering Ridge Family Dentistry to discuss my dental care, related issues, and accounts with the following persons, in addition to myself. If none, please leave blank.

_____ _____

Name Relationship

How did you hear about our office? _____

Dental Information

Date of last dental cleaning _____ Date of last dental xrays _____

How often do you brush your teeth?_____ How often do you floss? _____

Do your gums bleed when you brush or floss?	Y	N
Have you had any problems associated with previous dental treatment?	Y	N
Have you ever had an injury to your jaw or mouth?	Y	N
Have you ever been involved in a lawsuit regarding dentistry?	Y	N

Restorative Dentistry

Do you have active dental problems?	Y	N
If yes, please describe: _____		
If you have any missing teeth, would you like to discuss options for replacement?	Y	N

Periodontal Condition

Have you had periodontal (gum) treatments or "deep cleanings"?	Y	N
If yes, how long ago? _____		
Do you have any loose teeth?	Y	N
Do you experience dry mouth?	Y	N
Do you experience sensitivity?	Y	N

Clenching and Grinding

Are you aware of clenching or grinding your teeth?	Y	N
If yes, during the day?	Y	N
While you sleep?	Y	N
Do you experience headaches or sore jaw muscles upon awakening in the morning?	Y	N
Do you experience constant discomfort when opening or closing your jaw?	Y	N
Do you wear a night guard (bite splint)?	Y	N

Sleep Apnea

Have you ever been diagnosed with sleep apnea?	Y	N
If yes, what type of treatment do you utilize? _____		
Have you ever tried but subsequently given up on a CPAP machine?	Y	N

Orthodontics

Have you ever had orthodontic (braces) treatment?	Y	N

Whitening

Have you ever whitened your teeth?	Y	N
If yes, were you pleased with the result?	Y	N
Would you like to learn more about whitening options?	Y	N

Consent to Treat

I request and authorize the doctors and dental staff of Whispering Ridge Family Dentistry to perform dental services.

_____ _____

Signature of Patient Date

Minor/Child Consent

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including, but not limited to, X-rays and the administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the time that treatment is rendered.

Name of Minor(s)

_____ _____

Signature of Parent/Legal Guardian Date