5770 Wiles Rd, Coral Springs, FL 33067 Phone: (954) 255-5166

## PATIENT INFORMATION

Name			Date/	
Date of Birth//	Age	Sex DM DF	Marital Status	
Address	<b>C</b>	ity	Zip Code	
Cell Phone #	Email	Soci	al Security #	
Dental Insurance Company				
Employer	O	ccupation		
Spouse's Name		Spouse's Employer		
Spouse's Occupation		Spouse's Cell Phone #		
Spouse's Business Address		City	Zip Code	
Emergency Contact		Relationship to Patient:		
Emergency Contact's Phone #				
Physician's Name	Phone #	Last	: Exam Date/	
Physician Address		City	Zip Code	
	How did you hear about us?			
	<ul><li>A current patient:</li><li>A letter/postcard in the mai</li></ul>			
	□ Facebook			
	□ Instagram			
	☐ Google			
	□ WebMD			
	□ Other:			

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## MEDICAL HISTORY

Name	ate of Birth/ Sex □ M □ F		
Please let us know what brings you in today:			
Do you have, or have you had any of the following conditions?	? (Please check all that apply.)		
Are you required to pre-medicate with antibiotics before undergoing dental treatment?   yes   no   Blood problems (anemia)   Blood transfusion   Heart problems   Heart murmur, mitral valve prolapse, heart defect   Heart pacemaker   High blood pressure   Low blood pressure   Abnormal bleeding after any surgery (heavy bleeder)   Artificial joint or valves   Stroke   Tuberculosis or other lung problems   Kidney disease   Hepatitis, jaundice or other liver disease   Diabetes, type 1   Diabetes, type 2 Latest HbA1c reading & date:   Epilepsy or other neurological disorders   Thyroid problems   Osteoarthritis   Rheumatoid arthritis   Bone or joint problems   Herpes or cold sores   AIDS or HIV positive   Cancer/Tumor   Hayfever or sinus problems   Allergies   Asthma   Acid Reflux/Heartburn/GERD   yes   no Do you wake up many times at night?   yes   no Do you smoke, vape or use tobacco?   yes   no Do you smoke, vape or use tobacco?   yes   no Do you pregnant or plan to become pregnant?   yes   no Do you pregnant or plan to become pregnant?   yes   no Do you taking hormones or contraceptives?   yes   no Do you taking hormones or contrac	Are you allergic to, or have you reacted adversely to any of the following?    Latex - what are your symptoms?   Penicillin or other antibiotics   Aspirin     Codeine or other narcotics   Sulfa drugs     Barbiturates, sedatives or sleeping pills     Other:   Are you taking any of the following medications?     Aspirin   Anticoagulants (aka "blood thinners" e.g. Coumadin, Eliquis, Xarelto, Plavix, etc.)     Antibiotics or sulfa drugs   High blood pressure medicine     Antidepressants or tranquilizers   Insulin other diabetes drugs   Nitroglycerin     Cortisone or other steroids   Osteoporosis (bone density) medicine:   Natural supplements:     Medications: To the best of your ability, please list all medications taken, including quantity and frequency:     Describe any condition further, if needed:		
Do you have any cosmetic dental concerns? Please explain			
Patient's (or parent/guardian's) signature:			

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## CONSENT FOR TREATMENT

l,	, hereby authorize the dentists or designated staff at Creekside
Dental Excellence to take x-rays, study m	nodels, digital scans, photographs and any other diagnostic aids
deemed necessary by the dentists to mal	ke a thorough diagnosis of my dental needs, as well as to aid in
confirmation of successful treatment and	d to keep for treatment records.
I authorize the dentists and hygienists at	Creekside Dental Excellence to clean my teeth in a manner deemed
necessary prior to a diagnosis of my dent	tition otherwise, in order to properly visualize the teeth and provide
the most accurate diagnoses. Upon such	diagnoses, I authorize the doctors and designated staff to perform all
recommended treatment mutually agree	ed upon by me and to employ such assistance as required to provide
proper care.	
I agree to the use of anesthetics, sedative	es and other medication as necessary. I fully understand that using
anesthetic agents embodies certain risks	a. I understand that I can ask for a complete recital of any possible
complications.	
Lastly, I agree to be responsible for paym	nent of all services rendered on my behalf or my dependents'.
I understand that payment is due at the t	time of service unless other arrangements have been made.
Patient's signature:	Date:/
Parent or Responsible Party (print name,	, if different from patient):
Parent or Responsible Party's signature:	
Relationship to Patient:	

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#### WRITTEN FINANCIAL POLICY

Thank you for choosing Creekside Dental Excellence! Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

#### Payment options:

- Cash, Check, Visa, Mastercard or Discover Card

We offer a 5% courtesy accounting adjustment<sup>1</sup> to patients who pay for their treatment with cash prior to completion of care for treatment plans of \$1000 or more.

- Convenient monthly payment options from Sunbit<sup>2</sup>
  - Allow you to pay over time
  - Payment plans available starting with 0% APR
  - No annual fees nor pre-payment penalties

#### Please note:

<u>Payment</u>: Creekside Dental Excellence requires payment prior to treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of the progress of your treatment.

<u>Insurance</u>: For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment<sup>3</sup>.

Lateness/Failed appointments: If you find that you must change your appointment time/date, we require a minimum of 24 hours' notice so that we may make every effort to accommodate our other patients. If proper notice is not received 24 hours prior to your appointment time, a fee of \$25 may be charged. A fee of \$55 is charged for each instance thereafter, for patients who cancel within 24 hours or miss any future additional appointments. A 3rd missed appointment will be met with a letter of dismissal from the practice.

Long treatments: At the time of scheduling, a deposit of \$1000 is required for any and all treatment appointments which have an expected duration of 2.5+ hours (multiple porcelain or composite veneers, or placement of multiple implants). This deposit will be applied to payment for the respective treatment but will be deemed forfeited by a patient missing the appointment. If a patient arrives >10 minutes late or cancels the appointment within 24 hours, \$500 will be deemed forfeited and the patient will be required to replace the deposit, as this sum will no longer be applied to the treatment.

We do our utmost to provide timely services to all of our patients, so tardiness/missed appointments are not tolerated.

Returned ("bounced") checks will incur a \$40 fee. This fee covers the bank's processing fees charged to our office.

If you have any questions, please do not hesitate to ask. We are here to help each and every one of our patients get the dental care you want, need and deserve. Please indicate your understanding of the financial policy by signing below:

Patient, parent or guardian signature: _	Date:	/	1
Patient name (please print):			

<sup>1</sup>Not to be combined with any other discount or promotion.

<sup>2</sup>Subject to credit approval.

<sup>3</sup>If, however, we do not receive payment from your insurance carrier within 90 days, you are ultimately responsible for all payment of your treatment fees. The insurance contract is an agreement between you and the insurance company. We aim to help facilitate this agreement but cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

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# INDIVIDUAL MEDIA RIGHTS PHOTOGRAPHY, VIDEOGRAPHY AND/OR SOCIAL MEDIA CONSENT AND RELEASE FORM

For News Media, Social Media, Promotional Materials, Written Articles, Research and/or Photographs

l,	(Patient Name),		(Date of Birth)
hereby acknowledge and authorize	the doctors and/or designated st	taff, to use ar	ny and all x-rays, 3-D scans
(CBCT images), photographs and/or	r video content of me, my face, ja	ws and teeth	n, before, during and after
treatment for the following purpos	es (check all that apply):		
1. Dental <b>research</b> , dental <b>e</b> publications such as jour		inars, demon	strations, professional
2. Creekside Dental Exceller (formerly Twitter), TikTol websites and printed ma	k, Facebook, Google, Yelp) and for		
I consent to being "tag	ged" on social media @		on
3. I <b>decline</b> to consent.		Username	Platform
I acknowledge that if I provide permission information will be kept confidential to the willingly disclose my identity in a video, pr	e highest extent possible (other than if f	full face photogr	raphs are used and/or should I
I acknowledge that if I provide permission Dental Excellence, its doctors and any of it or privately, to distribute and to market co- identity or likeness in whatever media use limitation on where these materials may be	ts assigns and licensees, all rights to exhippies. I waive any and all rights, claims, on the validity of	ibit this work in or interests I ma	print and electronic form, publicly by have to control the use of my
I acknowledge that I will not receive comp	ensation, financial or otherwise, for the	use of these ph	notographs and/or videos.
Signature (Patient)	Date		

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#### NOTICE OF PRIVACY PRACTICE

We are required by law to maintain the privacy of your health information and to show you this notice about our practices and your rights concerning your health information.

In addition to our use of your health information for treatment, payment or healthcare operations or providers, only you may give us written revocable authorization to use your health information or to disclose it to anyone for any purpose.

We may disclose your health information to the following person/persons/medical professionals without additional written consent: We will use our professional judgment to disclose only health information that is directly relevant and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information. We will not use your health information for marketing communications without your written authorization. We may use or disclose your health information to provide you with appointment reminders (such as voicemail, email, postcards or letters). You have the right to look at or get copies of your health information as long as you sign a records release. (INITIAL) You have the right to request that we place additional restrictions on our use or disclosure of your health information. (INITIAL) \_\_\_\_\_ You have the right to request that we amend your health information. (INITIAL) You agree to allow us to send referrals to specialists & labs which may include personal health history and your x-rays. (INITIAL) You give us permission to call in any necessary prescriptions and share your personal health history with the pharmacist. (INITIAL) You agree to us sending electronic and paper claims to your insurance company which may include personal health history and x-rays. (INITIAL) If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information, you may complain to the U.S. Department of Health and Human Services or us. We support your right to the privacy of your health information and will not retaliate in any way should you do so. PATIENT ACKOWLEDGMENT My signature below acknowledges that I have read and understand the privacy practices of the office. Patient Name:

Signature

Date /

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## AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

Patient Name:	Date of Birth:		
(Initial below)			
I <u>DO</u> AGREE I <u>DO NOT</u> AGREE communicate with me electronically at the email address and/listed below. I will be sent appointment reminders/recall visits		the mobile p	hone number
I am aware that there is some level of risk that third parties mi communications. I further agree that I am responsible for imm with any updates to my email address and/or mobile phone no	ediately providing C		
My most preferred method of electronic communication:			
(Check one)			
Text Messaging			
Email			
(Initial below)			
I agree to receive requests for patient satisfaction of	nline reviews		
I also acknowledge that I can withdraw my consent to electro	nic communication	s at any time	e by calling the
dental office at (954) 255-5166.			
Patient Signature:	Date:		