New Patient Welcome Form

Thank you for choosing Cypress Creek Dental as your dental healthcare provider!

We are a family friendly dental office that provides high quality, honest, comprehensive dental care in a kind and comfortable setting where all patients are valued and cared for as individuals. Please take a few moments to answer the following questions so we can better assist you with your dental needs.

Cypress Creek Dental

Child – New Patient Welcome Form

Patient Information

Today's Date _____ D.O.B_____ Soc. Sec. #_____

Patient Name _____

Last First (Preferred Name)

Address: _____ Cell Phone _____

City:_____ State: _____ Zip: _____ Email:_____

Sex: ☐ M ☐ F ☐Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer_____ Business Phone _____

Business Address _____ Occupation _____

How did you hear about us? ☐ Current Patient, Who _____ ☐ Google ☐ Facebook ☐ Website

☐ Word of Mouth ☐ Drove by Office ☐ Online Reviews ☐ Other Source, Who or What _____

In case of emergency, who should we contact? _____Phone _____

Primary Insurance

Person Responsible for Account _____

Last Name First Name Initial

Relationship to Patient _____ Birthdate _____Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible party employed by _____ Business Phone _____

Business address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Secondary Insurance

Person Responsible for Account _____

Last Name First Name Initial

Relationship to Patient _____ Birthdate _____Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible party employed by _____ Business Phone _____

Business address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Children 12 & Under Medical and Dental History

Today's Date _____

Patient Name _____ D.O.B_____ Soc. Sec. #_____

Parent/Guardian's Name _____Relationship to Child_____

Emergency Contact (Name/Phone)_____

Medical History

1. Does your child have any current health problems?..... ☐Yes ☐No
   If yes, please explain: _____
2. Is your child under care of a physician?..... ☐Yes ☐No
   Name of Physician?_____
3. Is your child receiving any prescriptions, herbal, or OTC medications?..... ☐Yes ☐No
   If yes, what and when?_____
4. Has your child had any serious illness?..... ☐Yes ☐No
   If yes, what and when?_____
5. Has your child ever had surgery or is surgery contemplated?..... ☐Yes ☐No
   If yes, please explain:_____
6. Does your child have a heart murmur or any other heart conditions?..... ☐Yes ☐No
7. Does your child experience severe or prolonged bleeding?..... ☐Yes ☐No
   If yes, please explain:_____
8. Has your child had a history of nervous disorders?..... ☐Yes ☐No
9. Does your child have frequent headaches?..... ☐Yes ☐No
   If yes, please explain:_____
10. Is your child allergic to anything?..... ☐Yes ☐No
    If yes, please indicate: ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex ☐Nuts ☐Dyes
    ☐Other:_____
11. Do you have, or have you ever had:

ADD/ADHD……☐Yes ☐No
Asthma……☐Yes ☐No
Autism……☐Yes ☐No
Behavioral Problems……☐Yes ☐No
Cancer……☐Yes ☐No
Cerebral Palsy……☐Yes ☐No
Developmental Delay……☐Yes ☐No
Diabetes ……☐Yes ☐No
Epilepsy/Seizures/Fainting……☐Yes ☐No
Eating Disorders……☐Yes ☐No
Hay Fever/Seasonal Allergies……☐Yes ☐No
Hearing Impaired……☐Yes ☐No

Hepatitis/Jaundice……☐Yes ☐No
Hospitalizations……☐Yes ☐No
Kidney Infection……☐Yes ☐No
Liver Problems……☐Yes ☐No
Leukemia……☐Yes ☐No
Oral Herpetic Lesions……☐Yes ☐No
School Problems……☐Yes ☐No
Speech Impairments……☐Yes ☐No
Thyroid Problems……☐Yes ☐No
Rheumatic Fever……☐Yes ☐No
Take Pre-medication for Anything……☐Yes ☐No
If yes, what for? _____

Cypress Creek Dental

Children 13 & Under – Medical History

Children 12 & Under Medical and Dental History

Dental History

1. This is my child's first visit to the dentist..... ☐Yes ☐No
2. When does your child brush his/her teeth? ☐Upon Arising ☐After any Food ☐Right after Meals ☐Before Bedtime
3. Do you currently monitor your child's sugar intake in food, snacks, and drinks?..... ☐Yes ☐No
4. Does your child receive fluoride in their drinking water? ..... ☐Yes ☐No
5. Does your child receive supplemental fluoride at home? ..... ☐Yes ☐No
6. Have any cavities been noted in the past? ..... ☐Yes ☐No
7. Does your child suck his/her thumb or fingers? ..... ☐Yes ☐No
8. Were any teeth (baby or permanent) removed by extraction?..... ☐Yes ☐No
9. Has a space maintainer been recommended? ..... ☐Yes ☐No
10. Has a space maintainer been placed? ..... ☐Yes ☐No
11. Has your child had any problem with dental treatment in the past? ..... ☐Yes ☐No
12. Has anyone in the family, including parents, had orthodontics? ..... ☐Yes ☐No
13. Has your child ever received a local anesthetic? ..... ☐Yes ☐No
14. Has your child ever had occlusal sealants? ..... ☐Yes ☐No

    If yes, when?_____
15. Does your child think there is anything wrong with his/her teeth? ..... ☐Yes ☐No
16. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... ☐Yes ☐No
17. Does your child grind, clench, or brux their teeth? ..... ☐Yes ☐No
18. Does your child snore? ..... ☐Yes ☐No
19. Is there anything else that would be valuable for you dentist to know to best care for you child? ..... ☐Yes ☐No

    Explain:_____

Please provide information of who can bring the child/dependent to dental appointments.

Name _____Phone Number _____Relation_____

Name _____Phone Number _____Relation_____

Name _____Phone Number _____Relation_____

☐ **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.**

☐ **I authorize the release of any information concerning my child's healthcare, advice, and treatment provided for the purpose of improved treatment outcomes and/or evaluating and administering claims for insurances benefits.**

☐ **I attest to the accuracy of the information on this page and understand that it is my responsibility to inform the Doctor and the office staff of any changes in my child's medical status at the very next appointment, before any further treatment is rendered.**

Patient's/Guardian's Signature_____ **Date** _____

Financial and Authorization Policy

In order to establish optimal relationship and avoid misunderstandings and confusion regarding our policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required in full at the time services are rendered unless you are covered by an insurance company which Cypress Creek Dental participates. I understand that my insurance will be pre-verified, and I will be asked to pay all non-covered services, deductible amounts and co-pays at the time of service. We accept payment in the form of cash, check, Care Credit financing, or credit/debit card.

Prior to any services rendered, a treatment plan will be given to each patient. The treatment plan is only an **estimated** amount of payment expected from your insurance company according to your insurance plan benefits. **The estimated portion is due in full when services are rendered**. If for any reason your insurance denies any portion of your submitted treatment, you will be responsible for payment within 30 days after statement date.

☐ **I understand that failure to make payment when due is the basis for legal action and agree to pay any and all cost of collection, including attorney fees.**

☐ **I authorize and request that payment by an authorized insurance company may be payable to Cypress Creek Dental.**
Responsibility for Non-Covered Services:

As your health care provider, we at Cypress Creek Dental, wish to provide our patients with the best care possible. There may be services that we feel necessary for the maintenance of good health that are not covered by your insurance company. Your signature below verifies your agreement as the patient or responsible party of the patient to pay for those services.

We greatly value your time and strive to see every patient at their allotted appointment times. In order to best serve all our patients to the best of our abilities please arrive at your appointment on time. Also, we require a 24-hour notice for a cancelation or change in appointment times. There is a $25 missed appointment fee for missing your appointment or canceling the day of your appointment.

☐ **I have read the financial policy stated above and agree to all terms.**

Signature: _____ **Date:** _____

DENTAL INSURANCE

☐ **I understand it is my responsibility to know what my plan does and does not cover. Our Best Advice – Be Informed!**

- **Know Your Plan:** We do our best to give you as much information as possible, but your plan could be different than any of the other plans we have seen. Each employer provides something just a little bit different for their employees.
- **Deductible/Co-pay:** Most plans have a deductible or co-pay amount that the insured must pay before an insurance company will pay a claim.
- **Special Clauses and Limitations:** Some plans have special clauses in them where they do not cover certain procedures. Before having treatment done, it is always best for you to call the number on the back of your insurance card to know how your specific plan covers that treatment.
- **Waiting Periods:** Dental plans often apply a waiting period before certain services are covered. Waiting periods range from 6 to 12 months.
- **Yearly Maximums:** Even though your plan might cover a certain procedure (like a cleaning), if you have reached your yearly maximum for your plan – they will not pay any more money toward any treatment.

☐ **I have read and understand the above statements regarding my dental insurance and will be active in knowing my insurance plan and limitations it may have. I also understand that I am responsible for fees from services rendered that my insurance denies or does not cover completely.**

Signature:_____ **Date:**_____

AUTHORIZATION CONSENT

☐ **I authorize Cypress Creek Dental to send text messages, emails and recall cards for appointments and follow-ups. I can opt out at any time by calling 256-766-2606.**

Signature: _____ **Date:** _____

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are that are described in this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment, and health care operations. For example:

- *Treatment:* We may use or disclose your health information to a dentist, physician or other health care provider providing treatment to you.
- *Payment:* We may use and disclose your health information to obtain payment for services we provide to you.
- *Healthcare Operations:* We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- *Your Authorization:* In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- *To Your Family and Friends:* We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your care or with payment for your care, but only if you agree that we may do so.
- *Persons Involved in Care:* We may use or disclose health information to notify or assist in the notification of (including identifying/locating) a family member, your personal representative or another person responsible for your care, of your location, your general conditions, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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, -rays, or other similar forms of health information.
- *Marketing Health-Related Services:* We will not use your health information for marketing communications without your written authorization.
- *Required by Law:* We may use or disclose your health information when we are required to do so by law.
- *Abuse or Neglect:* We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- *National Security:* We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence or other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
- *Appointment Reminders:* We may use or disclose your information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

(Acknowledging Receipt of Policy)

Patient Signature:_____ **Date:**_____

For more info. about our privacy practices or for copies of this notice, please contact us at: info@cypresscreeksmiles.com.