OXFORD
DENTAL CARE

749 Oxford • Idaho Falls, ID 83401 • (208) 529-0420
Dr. Brent Cline, D.D.S

Patient Information

Personal

Patient's Name:_____ Date:_____

Social Security No.:_____ Sex (circle): M / F Date of Birth:_____/_____/_____ Phone No.: (_____)_____

Home Address:_____ E-mail Address:_____

Marital Status (circle): Single / Married / Divorced / Widowed / Seperated Referred to clinic by:_____

Employer:_____ Occupation:_____

Business Address:_____ Phone No.:_____

Spouse's Name:_____ Spouse's Employer: _____

Emergency contact:_____ Address:_____ Phone No.:_____

Insurance Information

(Please give your insurance card to the receptionist.)

Person Responsible for Bill:_____ Relationship to Patient:_____

Date of Birth:_____/_____/_____ Phone No.: (_____)_____ Address (if different):_____

Home Address:_____ E-mail Address:_____

Subscriber's Name:_____ Subscriber's S.S. No.:_____ Date of Birth:_____/_____/_____

Insurance Plan:_____ Group No.:_____ Policy No.:_____ Effective date:_____/_____/_____

Patient's relationship to subscriber (circle): Self / Spouse / Child / Other

Secondary Insurance (if applicable)

Subscriber's Name:_____ Subscriber's S.S. No.:_____ Date of Birth:_____/_____/_____

Insurance Plan:_____ Group No.:_____ Policy No.:_____ Effective date:_____/_____/_____

Patient's relationship to subscriber (circle): Self / Spouse / Child / Other

HIPAA Notice of Privacy Practice

I have been offered a copy of the HIPAA NOTICE OF PRIVACY PRACTICE

_____ _____
Patient/Guardian Signature Date

Consent for Treatment

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I understand I can ask for a complete recital of any possible risk of complications.

_____ _____
Patient/Guardian Signature Date

Financial Information

It is our intent to fully explain and inform you of all procedures, options, and fees in advance of treatment. Patients who carry insurance should understand that services are rendered and charged to the patient, not to the insurance company. We are happy to file the claim with your insurance carrier; however, all charges are your responsibility. Any estimate by this office regarding insurance benefits is only a guildeline. This office makes no guarantee of the insurance payment as estimated.

Deductible, estimated co-payments, and any treatments not covered by your insurance is due at the time of your visit.
We accept cash, personal checks, Visa, Mastercard, Discover, and Care Credit.
There will be an additional fee of $25.00 for returned checks. In the event of default, the undersigned agrees to pay interest on the unpaid balance of 1.75% per month (21% per year), reasonable attorney fees, court costs and a fee of 35% of the unpaid balance in the event the account is turned over to a third party collection agency. Delinquent accounts will be promptly referred to a collection agency.

I have read, understand and agree to the above stated financial policies of this office.
The information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Oxford Dental Care or the insurance company to release any information required to process claims.

_____ _____
Patient/Guardian Signature Date

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain_____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain_____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain_____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain_____

Are you taking any blood thinners (Warfarin or Coumadin)? ☐ Yes ☐ No _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Have you ever been treated for Osteoporosis? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain:_____

Do you have or have you had any of the following?

☐ AIDS/HIV Positive
☐ Alzheimers Disease
☐ Anaphlaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thryoid Disease
☐ Tonsilitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain:_____

(To be filled out by Office Staff) ASA Classification:

Dental History

Do you have any current dental problems? ☐ Yes ☐ No

If yes, please explain_____

Do your jaws click when you chew or are your chewing muscles always sore? ☐ Yes ☐ No

Have you noticed any growths or sore spots around your mouth? ☐ Yes ☐ No

Have you experienced an unusual reaction to dental anesthesia or nitrous oxide gas? ☐ Yes ☐ No

Do your gums bleed when you brush? ☐ Yes ☐ No

Have you had any difficult extractions or any prolonged bleeding following extraction? ☐ Yes ☐ No

Have you ever had trench mouth or pyorrhea? ☐ Yes ☐ No

Are any areas of your mouth sore or sensitive to sweets, hot, or cold? ☐ Yes ☐ No

Do you habitually clench your teeth during the day or night? ☐ Yes ☐ No

Have you ever had a severe reaction to dental treatment? ☐ Yes ☐ No

When did you visit a dentist last? _____

How many x-rays were taken?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____DATE_____

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We have made it a priority to provide multiple options for our patients so that they are able to comfortably afford the costs of their dental care. We proudly offer the following financial options so that our patients have the opportunity to decide which payment option best suits their needs.
If you have any questions or concerns, please ask! We are here to help.

Financial Options for Patients with Dental Insurance

Our office will gladly work with most insurance companies to help our patients maximize their insurance benefits. Most insurance companies do not cover 100% of treatment fees. Because of this, ***we ask our patients to pay any applicable copay or deductible and their estimated patient portion at the time service is rendered.*** We will gather the *closest estimates* possible, however, we can make no guarantee of any estimated or actual amounts. Payments and coverage can only be determined by the insurance company.

Please note that the ultimate responsibility for all charges belongs to the patient. Any amount not paid or covered by the insurance is the responsibility of the patient.

Cash, Check, Credit Card

☐ We accept cash, checks, and all major credit cards. Please note that our office does not have access to change for cash payments. Any change due to the patient after a cash payment can be left in the account as a credit for future services.

CareCredit Card

CareCredit is a great third-party financing solution for patients with or without insurance. They offer low minimum monthly rates and often offer deferred interest if paid within the timeframe of your individual agreement. You can apply online at *carecredit.com/apply* or even over the phone by calling *(800) 677-0718.* With CareCredit you can get your approval credit on the spot and, if approved, can start using your account the same day!

☐ **Using CareCredit *with* insurance:** Fees for services not covered by insurance can be paid with a CareCredit card at the time services are rendered. CareCredit does not allow prepayments.

Monthly Automatic Payments

If you are not able to pay for your entire treatment costs before or at the time of your appointment, this option helps to minimize your initial payment and allows for more time to pay off the remaining amount. This option also provides a level of convenience and ease for both the patient and our office, ensuring that the patient does not have to stress about missing payments or paper billing.

☐ **Monthly ACH Payments:** After a down payment of 50% of the estimated patient portion for restorative treatment cost is made, the remaining sum can be paid in 2 monthly payments, which are withdrawn automatically by our local bank, starting on either the 1st or 15th of the next calendar month.

I have had an opportunity to ask any questions I may have regarding my financial options listed above.
I am aware that my total treatment cost is my responsibility, and that payment is DUE at the time of my appointment.

Patient/Guardian Signature_____ **Date** _____

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We have made it a priority to provide multiple options for our patients so that they are able to comfortably afford the costs of their dental care. We proudly offer the following financial options so that our patients have the opportunity to decide which payment option best suits their needs.
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Financial Options for Patients Without Insurance

In-house Membership Plan

We are now offering in-house membership plans! These plans offer our highest discounted rates on restorative treatment (20%!). We have plans for every member of your family. You can enroll today and use your benefits at your next appointment! *Ask an office member for details!*

Cash, Check, Credit Card

☐ **Prepayment:** We are happy to offer a 10% courtesy adjustment on all restorative treatment for patients without insurance if the total is paid in full before or at the time of scheduling the first treatment appointment.

☐ **At Time of Service:** If prepayment is not an option, we offer a 5% courtesy adjustment on all restorative treatment for patients without insurance when the total is paid in full at the time of the first treatment appointment.

CareCredit Card

CareCredit is a great third-party financing solution for patients with or without insurance. They offer low minimum monthly rates and often offer deferred interest if paid within the timeframe of your individual agreement. You can apply online at *carecredit.com/apply* or even over the phone by calling *(800) 677-0718.* With CareCredit, you can be approved on the spot and can start using your account the same day!

☐ **Using CareCredit *without* insurance:** We are happy to offer a 5% courtesy adjustment on all restorative treatment for patients without insurance if the total is paid in full at the time of the first treatment appointment. Unfortunately, due to CareCredit's terms, we cannot accept prepayments with a CareCredit Card.

Monthly Automatic Payments

If you are not able to pay for your entire treatment costs before or at the time of your appointment, this option helps to minimize your initial payment and allows for more time to pay off the remaining amount. This option also provides a level of convenience and ease for both the patient and our office, ensuring that the patient does not have to stress about missing payments or paper billing.

☐ **Monthly ACH Payments:** After a down payment of 50% of the total restorative treatment cost is made, the remaining sum can be paid in 2 monthly payments, which are withdrawn automatically by our local bank, starting on either the 1st or 15th of the next calendar month.

I have had an opportunity to ask any questions I may have regarding my financial options listed above.
I am aware that my total treatment cost is my responsibility, and that payment is DUE at the time of my appointment.

Patient/Guardian Signature_____ **Date** _____

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Appointment Cancellation Policy

We pride ourselves in providing the time for personal attention each of our patients deserve. We will always respect your time and make every effort to keep you from waiting. As a result, your appointment time in this office is set aside exclusively for you.

When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. This is why we have a cancellation policy in place.

We ask that if you must reschedule your appointment, that you please provide us with at least 24-hours notice. This courtesy makes it possible to give your reserved time slot to another patient.

There is a charge of $30.00 per hour for not showing up for scheduled appointments or failing to give a 24-hour notice of needing to reschedule or cancel.

If you have any questions regarding this policy, please let our team know and we will be glad to clarify any questions you have.
We thank you for choosing our office!

I, _____ (print name) have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms.

Signature: _____Date: _____