Cross Creek
DENTAL CARE
Family and Cosmetic Dentistry

Patient Information

Name: _____
(Last) (First) (Middle)
Name you prefer to be called: _____ Mother's Maiden Name: _____
Date of Birth: _____ Social Security Number: _____
Street Address: _____ Apt. #: _____
City: _____ State:_____ Zip Code: _____
Home Telephone #: _____Work #: _____ Cell #: _____
Employer_____ Address_____
Whom may we thank for referring you? _____E-mail Address:_____
Emergency Contact: _____ Phone: _____

Dental Insurance

Primary Ins. Co. Name: _____ Group#_____
Ins. Billing address:_____Employer:_____
Insured's Name: _____Date of Birth: _____ Member ID#:_____

Dental History

Dental Concerns:_____
Date of Last Dental care:_____**Date of Last Dental x-rays**:_____

Medical History

Date of Last Physical Exam:_____ Name of Current Physician: _____
Are you now or have you recently been under a physician's care? _____ Yes _____ No
Reason: _____
Have you ever been a patient in a hospital or had any serious illness? _____ Yes _____ No
Explain: _____
Allergies: _____
Current Medications_____
_____

Check any of the following that you have had or suspected:

___ Arthritis
___ Rheumatic Fever
___ Heart Trouble
___ Heart Murmur
___ High/Low Blood Pressure
___ Chest Pain
___ Stroke
___ Shortness of Breath
___ Asthma or Hay Fever
___ Sinus Trouble
___ Hepatitis or Jaundice
___ Liver Disease
___ Cancer or Tumor
___ Tuberculosis
___ Diabetes
___ Kidney/ Bladder Trouble
___ Anemia
___ Lung Disease
___ Venereal Diseases
___ Blood Diseases
___ Prolonged Bleeding
___ Fainting Tendency
___ Epilepsy
___ Thyroid Disease
___ Glaucoma
___ Radiation Treatment
___ Mental Disorders
___ HIV or AIDS
___ Prosthetic Joint Replacement
___ Blood Transfusion

Check any of the following that you are taking or have taken:

___Cortisone Drugs
___Steroids
___Anticoagulants
___Blood Thinners
___Tranquilizers
___Sedatives

Women Only:
Are you pregnant? _____ Yes _____ No If yes, how many months? _____ Are you breast feeding? _____ Yes _____ No
Are you presently taking any routine medicines? (Birth control pills, shots or implant, hormone therapy, etc.) ____ Yes____ No
I have read and understand theinformation in this form. I give permission for myself/my child to have dental treatment.

Signature: _____ **Date:** _____/_____/_____

THANK YOU FOR CHOOSING OUR OFFICE FOR YOUR DENTAL CARE NEEDS!!

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Written Financial Policy

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

Payment Options:

Our office accepts:

- Cash or check, Visa®, MasterCard®, American Express® or Discover Card®
- Special financing options with convenient monthly payments available with the CareCredit healthcare credit card
    - Allow you to pay over time
    - No annual fee

Please note:

If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $75 is charged for patients who miss or cancel more than 1 times in a calendar year without 24-hour notice.

Cross Creek Dental Care Of Marion charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

CareCredit is a credit card offered by Synchrony Bank and is NOT an in-house credit program offered by Cross Creek Dental Care. You may apply for CareCredit healthcare credit card and if approved, use it at Cross Creek Dental Care's office. However the CareCredit card agreement is between you and Synchrony Bank.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I acknowledge that I have been provided the Eric P. Buck, DDS, Inc. (Cross Creek Dental Care of Marion) Notice of Privacy Practices (HIPAA):

• It tells me how the dentist will use my health information for the purposes of my treatment, payment for my treatment, and the dentist's dental care operations.

• The Notice also explains in more detail how the dentist may use and share my health information for other than treatment, payment, and dental care operations.

• The dentist will also use and share my health information as required/permitted by law.

Patient's Complete Legal Name: _____
(please print patient or legally authorized representative)

Relationship of Legally Authorized Representative to Patient: _____

Patient's SSN: _____

Patient's DOB: _____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain writing acknowledgment of receipt of our Notice of Privacy Practices and acknowledgment could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibit obtaining acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (please specify) _____