Welcome!

Thank you for choosing our office for your dental care. We promise to do our best to provide you with the finest care available. If you ever have any questions, please don't hesitate to call.

PATIENT INFORMATION

NAME______________________________ DOB_____/______/_____ PREFERRED CONTACT # Home (____)__________
Last First Middle Mobile(____)__________

ADDRESS___________________________ CITY______________________ STATE________________ ZIP________________

MALE___ FEMALE___ MARRIED___ SINGLE___ CHILD___ EMAIL___________________________________

SSN_______________________ WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

EMPLOYER/SCHOOL_____________________________________ EMPLOYER/SCHOOL #______________________

EMERGENCY CONTACT_______________________________________ PHONE #______________________________

ADDRESS___________________________ CITY______________________ STATE________________ ZIP________________

RESPONSIBLE PARTY

NAME OF PERSON
RESPONSIBLE FOR ACCOUNT_____________________________________ RELATION TO PATIENT__________________

ADDRESS____ HOME PHONE# _______________________

BIRTHDATE ___________________________ WORK PHONE # ___________________ MOBILE #__________________

EMAIL____ CURRENTLY A PATIENT IN OUR OFFICE? YES___NO ___

SSN_____________________________

PRIMARY INSURANCE INFORMATION (PLEASE PRESENT CARD)

NAME OF INSURED____ DOB_______________________________________

RELATION TO PATIENT ____________________________________ SOCIAL SECURITY NUMBER __________________

EMPLOYER ____ WORK # ______________________________

INSURANCE COMPANY _______________________ ID #_________________ GROUP # ______________ PHONE #________________

SECONDARY INSURANCE (PLEASE PRESENT CARD)

NAME OF INSURED____ DOB_______________________________________

RELATION TO PATIENT ____________________________________ SOCIAL SECURITY NUMBER __________________

EMPLOYER ____ WORK # ______________________________

INSURANCE COMPANY _______________________ ID #_________________ GROUP # ______________ PHONE #________________

- OVER -

FINANCIAL POLICY

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. PAYMENT IS DUE IN FULL AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. IF THIS ACCOUNT IS ASSIGNED TO AN OUTSIDE COLLECTION AGENCY FOR COLLECTION, I/WE AGREE TO PAY ALL ATTORNEY FEES WITH OR WITHOUT SUIT, COURT COSTS, AND A COLLECTION FEE OF UP TO 40%, WHICH MAY BE ADDED TO THE OUTSTANDING BALANCE OF MY ACCOUNT. I/WE AGREE TO PAY INTEREST AT THE RATE OF 1 ½% PER MONTH (18% PER YEAR).

CONDIE AND TUFT FAMILY DENTISTRY IS COMMITTED TO PROVIDING ALL OF OUR PATIENTS WITH EXCEPTIONAL CARE. WHEN A PATIENT CANCELS WITHOUT GIVING ENOUGH NOTICE, THEY PREVENT ANOTHER PATIENT FROM BEING SEEN. PLEASE GIVE 48 HOURS NOTICE IF YOU NEED TO MAKE ANY CHANGES OR CANCELLATIONS. IF PRIOR NOTIFICATION IS NOT GIVEN, YOU WILL BE CHARGED $48.00(PER HOUR) FOR THE MISSED APPOINTMENT.

We want to stay in touch with you regarding your account. Since most people only have cell phones we will need your permission to call and message your cell phone. In order for us, or for any other person or entity who provides goods or services to you in connection with this agreement, to contact you regarding servicing your account(s), you expressly authorize us to contact you by telephone at any telephone number, including any cellular, mobile, and other wireless telephone numbers that you have or may attain. You acknowledge that such calls could result in charges to you by your telephone carrier. You also expressly authorize us, and any other person or entity that provides good or services to you in connection with this agreement, to contact you by sending text messages or e-mails to any of your telephone numbers or e-mail accounts. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collections company or companies which may be assigned.

SIGNATURE: ____ **DATE:** ______________________________

(PATIENT OR RESPONSIBLE PARTY)

CONSENT TO PROCEED

I authorize Dr. Brian L. Tuft DMD and/or Jared C. Condie DMD and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled in to the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

PATIENT NAME____

SIGNATURE: ____ **DATE:** ______________________________

(PATIENT OR RESPONSIBLE PARTY)

WITNESS____ DATE: ______________________________