

FLATROCK FAMILY DENTISTRY

DEREK P. WALROD, DDS

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**PLEASE COMPLETE AND
RETURN TO FRONT DESK**

NAME		Last	First	Middle		
ADDRESS		Street or P.O. Box #		City	State	Zip Code
						PHONE NUMBER HOME: WORK:
AGE; Yrs.	BIRTH DAY Mo. Day Year		BIRTHPLACE		() Married () Unmarried () Separated	SOCIAL SECURITY NO. (If child, parent's)
						DRIVER'S LICENSE NO.
OCCUPATION		EMPLOYER		HOW LONG EMPLOYED		ADDRESS & PHONE NO.
PERSON RESPONSIBLE FOR BILL (If married, spouse's name)		AGE		ADDRESS RELATIONSHIP		SOCIAL SECURITY NO.
						DRIVER'S LICENSE NO.
OCCUPATION		EMPLOYER		HOW LONG EMPLOYED		ADDRESS & PHONE NO.

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME		Date of Birth
SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	WORK PHONE
INSURANCE COMPANY NAME	GROUP OR UNION NAME	GROUP OR LOCAL NUMBER
EMPLOYER'S NAME	FULL ADDRESS OF EMPLOYER	

GETTING TO KNOW YOU

- Why did you select our office?

 - Whom may we thank for referring you?

 - Is another member of your family or relative a patient in our practice?

 - Person to contact for emergency: _____
Phone: _____
 - When was your last dental visit? _____
 - When was the last time you had complete dental X-rays taken?
Physician: _____
 - Have you ever had any teeth removed? _____
How long have these teeth been missing? _____
Have these teeth been replaced? _____
- How? ☐ Bridge ☐ Partial ☐ Denture ☐ Implants

PAYMENT ALTERNATIVES

Please check appropriate box

- ☐ 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.
- ☐ 2. Cash and personal checks are accepted as your treatments are provided.
- ☐ 3. If you have dental insurance, we want you to receive the full benefit of it. Our staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment; another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.
- ☐ 4. Mastercard, Visa and Discover.
- ☐ 5. For long term or extended payments, we offer a healthcare financing program, which when you are accepted, will allow extended small monthly payments for the treatment received.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 medication 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: _____Do you take, or have you taken, Phen-Fen or Redux? ☐ 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? ☐ Yes ☐ NoTaking oral contraceptives? ☐ Yes ☐ NoNursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

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

Comments: _____

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 _____

CONSENT TO PERFORM DENTISTRY

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand and we are ready to answer any of your questions or explain anything.

1. I hereby authorize and direct the dentist(s) of Flatrock family Dentistry, P.C. and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiography's (x-ray), or diagnostic aids after the risks and benefits have been explained and I have approved treatment.
 - A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
 - B. Application of plastic "sealants" to the grooves of the teeth.
 - C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
 - D. Replacement of missing teeth with dental prostheses (bridges, partials, full dentures).
 - E. Removal (extraction) of one or more teeth.
 - F. Treatment of diseased or injured oral tissues (hard and/or soft).
 - G. Use of sedative drugs to control apprehension and/or disruptive behavior.
 - H. Treatment of malposed (crooked) teeth and/or oral developmental abnormalities.
 - I. Use of general anesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risk/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications with the understanding my identity will never be divulged.
7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and regular office visits as scheduled by the dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it in writing.

Date: _____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

Signature of Patient/Parent/or Guardian: _____

Witness: _____

Flatrock Family Dentistry, P.C

Financial Policy

Dear Patient:

Thank you for selecting us as your dental care provider. The following information describes our financial policy. Our primary goal is that you receive the optimal treatment needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask any one of our helpful team members.

Payment for services is due at the time the services are rendered. We accept cash, personal checks, and for your convenience most major credit cards. We also offer 12 month no interest financing through Care Credit. We will also help you process your insurance claims as long as it is up to date and complete.

Your insurance company is a contract between you, your employer and your insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.

1. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in every contract. Some insurance companies arbitrarily select certain services they will not cover.
2. Deductibles and Co-payments are due at the time of treatment.
3. If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to expedite the claim process.
4. If the insurance company rejects or refuses to pay your claim within 45 days, we require that you pay the balance in full.
5. Balances older than 90 days may be subject to additional collection fees and interest charges. Returned checks have a \$50.00 charge added to the amount of the returned check.

Please note that, unless your appointment is canceled 24 hours in advance, you may be charged accordingly for a missed appointment. Please call us as soon as possible if you have to reschedule an appointment.

We understand that temporary financial problems can occur, and this may effect your timely payment of our balance. We encourage you to communicate any such problems with us so that we can assist you in the management of your account.

Again thank you for choosing Flatrock Family Dentistry as your dental health care provider. We appreciate your confidence in us and the opportunity to serve you.

Patient Signature: _____

Date: _____

Insurance Information Disclaimer

It is very important for any dental patient to have some understanding of how dental insurance works. Your employer contracts with an insurance company, the insurance company creates a custom tailored policy based on what your company is willing to pay as a premium. This policy is unique to your company although it may share some similarities to other policies. The insurance company has the ability, based on the legal document "policy", to pay or not pay any claim at any time or to exclude certain procedures etc to limit their exposure. Their legal relationship is with you the patient and not the dental office which is a third party provider.

The information is very limited as to what they tell us. When we call on your benefits we receive some information relevant to the patient being registered in the insurance program and usually a few lines of percentage of coverage's. We receive no information on specifics of your policy. What we do get on all of the information they send to us is in bold letters that states "Notice: Provider acknowledges and understands that the information contained herein reflects current files. Claims will be processed according to benefit and membership information on file at the time of processing. Therefore, the information contained herein does not guarantee reimbursement."

Please understand as a patient at our office we do everything possible to ensure that you get your maximum benefit from the insurance. When the insurance company processes a claim is anybody's guess. It can be upwards of 6 months for them to process although that is an exception and not the rule. At the end of the day the insurance company holds all the cards, they can refuse or deny anything they choose. That is why it is important that you understand that when you receive a treatment plan from our office that it is an estimate only. We cannot possibly know all the ins and outs of the thousands of insurance policies out there.

It's important for you to have a copy of your policy and some understanding of it. This document is our attempt to avoid any financial misunderstandings. In the end you are responsible for anything your insurance company doesn't cover for any reason. Our goal as an office is to give you the best treatment possible and meet or exceed your expectations. We devote a great many hours discussing how we might make it a better experience for you the patient. Thank you for your continued business and confidence you have with our office. By signing this document I have read and understand the above information.

Signature _____

Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

