Valerie Pollock, DDS
Family Dentistry

Patient Information

Patient Name: _____ Date: _____
Last, First Middle Initial (Preferred Name)

Gender: ☐ Male ☐ Female Family Status: ☐ Single ☐ Married ☐ Child

If patient is a child, Parents Name_____

Patient Social Security #: _____ Patient Birth Date: _____

Phone (Home): _____ (Cell): _____ Email:_____

Mailing Address: _____
Street

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had or do you currently have any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Are you taking any blood thinners or have you taken any in the past?

Name of Blood Thinners
_____

_____

Thyroid_____

Are you taking any of the following bone density meds?
☐ Aredia ☐ Boniva
☐ Bonefos ☐ Didronel
☐ Zometa ☐ Fosamax
☐ Actonel ☐ Skelid
☐ Forteo

Do you snore_____History of Sleep Apnea:_____Do you use/have used a C.PAP:_____

- Please list the medications you are currently taking (Please write N/A if you are not currently taking any medications):
_____
_____

- Please list any allergies you may have:_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No

- Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ Date: _____
Signature of patient, parent or guardian

Cancellation Policy

We consider the time set aside for your appointment to be your reserved time. Consequently, when you do not provide us with a 48-hour courtesy call our other patients waiting for an open appointment are affected. In order to allow all of our patients to experience the best available appointment arrangements, please be aware of our cancellation policy and associated fees. Please remember that you are a valuable member of our dental practice. This policy is constructed to better serve all our patients, and we thank you for your cooperation!

• Please cancel during normal business hours with at least 48 hours notice: Please be certain that you have cancelled at least 48 hours prior to your appointment. One of our team members will gladly speak with you regarding rescheduling.
• Emergencies: We understand that true emergencies do arise. Appointments missed by an individual due to reasons beyond his/her control will be taken under careful consideration.

Our policy regarding cancellations/no shows and associated fees:

• The first appointment that is cancelled without 48 hours notice- a verbal reminder of the cancellation policy will be given.
• The second appointment that is cancelled without 48 hours notice - a $25 fee will be charged to your account.
• The third appointment that is cancelled without a 48 hours notice – a $25 fee will be charged to your account and your appointment will be rescheduled at the discretion of our office.

Broken appointment charge of $50.00 is applied to your account for any missed appointment or reschedule within 48 hours of a Saturday appointment.

I have read this policy. I understand, if I do not reschedule with a 48 hours' notice period, I will be subject to a $25 appointment fee.

X _____ _____

Signature of patient or parent if minor. Date

Financial Policy

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

We will be happy to work with you and your insurance carrier to maximize your benefits. Payment of insurance deductible and co-insurance amounts are expected at the time of your visit. By signing this you choose to assign your insurance benefit directly to us. This means we will then bill your carrier for the services rendered on that day. If payment is not received from your insurance carrier within the 90 day period the balance owed becomes the patients' sole responsibility. However, we will continue on your behalf to follow through with the claim process. Some insurance carriers send payments directly to the patients instead of the provider of service. It is your responsibility to then endorse the check and submit them to our office or pay for services in full at the time they are rendered.

We accept cash, check, visa, Mastercard and care credit. There will be a fee of $30 for a returned check.

We value our patients and understand that financing may sometimes be difficult. Although our office is a private practice and not a dental clinic, we strive to help you reach optimal dental health by participating with some dental insurances and working with Preferred Provider Organizations (PPO) plans. Whenever possible, we will do our best to assist you and guide you to best utilize and maximize your benefits and therefore reducing your own "out of pocket" expense. However, it is the patient's responsibility to be aware of their individual benefits and limitations to their plan, so any problems or misgivings can be prevented. We treat our patients based solely on their dental needs and wants……we do not treat only according to what your insurance will or will not cover. We strive to give you the highest quality of dentistry and total patient care that you deserve. The staff at Pollock Family Dentistry will provide you with an estimation of your "out of pocket" expense, but once insurance has paid there still may be a balance that will be the patient's responsibility. From time to time, an insurance company will provide inaccurate information about a patient's plan. This is beyond our control and creates confusion about what a patient may owe. Because of this, it is imperative that you familiarize yourself with your unique plan. **Ultimately, all fees are the responsibility of the patient regardless of whether or not they have insurance.** All payments are due on or before the day of treatment. For your convenience we accept cash, checks, CareCredit, Lending Club and all major credit cards.

I have read and understand the terms of the above financial agreement.

X _____ _____ _____

Signature of patient, parent or guardian Date Relationship to Patient

Emergency Contact Information

Name:_____ Relationship:_____ Phone Number:_____

Consent for Services

While serious complications associated with dental procedures are very rare, we would like our patients to be informed about the various procedures involved in dentistry and have their consent before starting treatment. The following risks of complications exist with general dental treatment choices: Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections include (but not limited to) Swelling, sensitivity, bleeding, infection, nerve damage, sinus exposure, damage to adjacent teeth, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing, the possibility of perforations of the tooth or root, damage to existing restorations (fillings), the possibility of a split or fractured tooth, the possibility of separation of a portion of an instrument that cannot be removed from within the tooth, pain and anesthesia risks, also in very extreme cases death. It is very important that you inform the dentist if you are currently taking any medications for bone density (ie. Boniva, Fosamax, Didronel, Skelid, Actonel, Zometa, Bonefos, Aredia) because these medications can lead to osteonecrosis (severe bone loss) of the jaw bone. I hereby authorize the above named doctor to proceed and I am aware that I do have the option to be referred to a specialist before and at anytime during the procedure.

The risks of complications from medications used/prescribed with general dental treatment include, but are not limit ed to, drowsiness, lack of awareness and coordination, nausea, allergic reaction, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe. Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other/additional contraceptive measures be taken during the administrations of antibiotics.

I, the undersigned, being the patient (parent or legal guardian of above minor patient of incompetent adult), consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor.

I understand that during the course of my/the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those planned. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made concerning the results of treatment that I/the patient will receive.

I have read the above conditions of treatment and payment and agree to their content.

X_____ _____ _____

Signature of patient, parent or guardian | Date | Relationship to Patient

Dr. Valerie Pollock's Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have reviewed a copy of this office's Notice of Privacy Practices.

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
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

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