Welcome to our practice! We are looking forward to caring for your dental health needs. Before we get started, we wanted to share with you our vision as a team and our mission as a practice. We hope that these service aspirations help ensure you have a positive dental experience.

- **Our Vision** – Our vision is to provide an experience that exceeds our patient's expectations in every interaction, so that when you leave, you are in optimal oral health. Our community is positively impacted by the values that we are centered on. We aim to create a team culture that embodies integrity, dedication, accountability, and compassion for each other and our patients as we strive for continual improvement.
- **Our Mission** – Our purpose is to guide our patients along the path of optimal dental health by delivering the highest possible level of care in a friendly, safe, and comfortable environment. Our team of professional and compassionate employees diligently strive to improve patient health, appearance, self-confidence, and overall quality of life. We realize that this type of patient care is only possible if we practice with integrity. We strive to center our business practices on the highest possible standards of care available in dentistry for both our employees and patients, as this aligns with our vision of continual improvement. We are committed to making a positive impact in the lives of our team and patients alike and make a daily effort to treat every individual like family.

While you are in our office, we will do our best to present recommendations as if we were treating one of our own family members. We aspire to pay special attention to our patient's level of comfort by actively asking how you're feeling.

Furthermore, we use various tools to ease potential discomforts such as:

- Nitrous oxide (laughing gas)
- Numbing agents
- Oral sedation

We also utilize the latest proven technology such as digital x-rays and intra-oral cameras with tablet PCs to help reduce the level of radiation you experience and make it easier for you to see what is going on in your own mouth.

We take these goals so seriously, if we fall short of your expectations, please let us know.

Conversely, if we do a good job, the best way to show us your appreciation is by referring other people you care about to our practice.

Again, welcome. We all look forward to meeting you!

FINANCIAL ARRANGEMENTS FOR OUR PATIENTS

Our office wants all of our patients to be able to comfortably afford dental care. We proudly offer the following financial policy so that you can have the opportunity to decide which payment option best suits your needs.

Insurance: We are contracted (in-network) providers with Delta Dental Premier and coordinate out-of-network benefits with many other dental insurance companies and PPO policies. We are not contracted with Medicaid. No matter your coverage we will provide you with excellent dental care! We will accept assignment of benefits. This means that you must sign the portion of your insurance form that "assigns" payment to our office. Most dental insurance plans **do not cover 100%** of the cost of your treatment. **Your PPO insurance company sets the price;** we have no control of the price your insurance company establishes. Because of this and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will **estimate** your coverage as closely as possible, but until we actually receive the payment from the insurance company, it is just an estimate. We will **assist** you in dealing with your insurance company by filing the claims, but the ultimate responsibility lies with you. **Our estimates are subject to final approval by your insurance company and could therefore change the amount due to our office.**

- **How does dental insurance work best?** Dental insurance works best for diagnostic and prevention-based services such as exams, x-rays, and cleanings. Depending on that, it may also offer partial coverage for minor restorative procedures such as a limited number of fillings.
- **When does dental insurance not work well?** Dental insurance typcially does not work well for major procedures such as crowns, implants, orthodontics, and other surgical procedures. When a patient has a complex treatment plan or requires advanced restorative procedures, dental insurance provides a minimal amount of financial support.
- **What about the cost of dental work? What can be done?** Dental care is an investment in your health and appearance. We understand that each patient's treatment and financial requirements are unique and will create a customized plan that meets your needs. Furthermore, we offer two exceptional discount plans and are conveniently open on evenings and Saturdays to accommodate a wide variety of schedules. It is important to us that our patients have access to care that they need and deserve. If you have any questions about your care, please speak with one of our treatment coordinators who can help answer your questions.

VIP Dental Membership Program: If you have no insurance, no problem – we've got you covered with our VIP dental membership program. Ask about our in-house plan which include two cleanings, exams, and x-rays a year and give you major discounts on all other dental services. In some cases, our plan competes with or beats other plans.

Payment Options

- **We accept VISA, MasterCard, Discover, and American Express.** Many of our patients prefer this option because they earn rewards points.
- **Sunbit Financing** (credit check required): Upon qualifying you will be extended a line of credit by an outside financing company (Sunbit)with multiple payment term options. Loan amounts vary from $50-$10,000 based on approval. A down payment is required. You can find out in just a few moments if you are approved.
- **Easy-Pay Financing:** Our in-house financing option allows you to split your purchase into flexible monthly payments with no interest. Payment term options vary based on the purchase amount. 50% of the purchase total is due on the day the service is rendered. A valid debit/credit card will be kept on file and processed for the approved amount on a monthly basis.

We would be happy to work with you to plan out the most appropriate arrangements for your budget. Financing your treatment allows you to start your dental care immediately and spread the payments over a period of time. Most importantly, it offers you the opportunity to enjoy the benefits of your dental health without the financial strain.

We want to thank you for trusting us as your health care provider. We appreciate the opportunity to serve you.

Clocktower Family Dental

Welcome!

Please provide your dental insurance card and/or the following information

Name ______________________________________ Date of birth ________________

Do you have insurance coverage? Yes _____ No ______

Primary dental insurance:

Please provide the following information:

Primary subscriber name: ____

Primary subscriber date of birth: ____

Employer sponsoring the insurance: ______________________________________

If you do not have your insurance card available, please provide the following information:

Insurance company name: ____

Insurance company phone number: _______________________________________

Member ID or social security: ____

Secondary dental insurance (if applicable):

Please provide the following information:

Primary subscriber name: ____

Primary subscriber date of birth: ____

Employer sponsoring the insurance: ______________________________________

If you do not have your insurance card available, please provide the following information:

Insurance company name: ____

Insurance company phone number: _______________________________________

Member ID or social security: ____

For office use only:

_____ Eligible
_____ Calendar year or ___ Fiscal year/month ____________________
_____ Waiting period ________________________
_____ Benefits checked
    _____ Yearly max
    _____ Deductibles
    _____ Remaining benefits
    _____ Coverage profiles/percentages
_____ Insurance entered
_____ Staff initials

Patient Information

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's name ______________________ Preferred name __________ Birth date __________

Responsible party ____________________ Cell phone ___________ Email ________________

Address ________________________ City _____________ State _____ Zip __________

Social security _______________ Employer _________________ Home phone ___________

Married ☐ Spouse's name ____________ Cell phone __________ Spouse's employer __________

Medical History

Have you experienced any of the following?

- ☐ Heart attack
- ☐ Chest pain or angina
- ☐ Stroke If yes, date ________
- ☐ Shortness of breath
- ☐ High or low blood pressure
- ☐ Heart murmur
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Easy bruising
- ☐ Bleeding disorder ______________
- ☐ Anemia
- ☐ Ever required a blood transfusion
- ☐ Hepatitis, jaundice, or liver disease
- ☐ Alcoholism or drug abuse
- ☐ Hay fever or sinus trouble
- ☐ Asthma
- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Artificial joint (hip, knee, etc.)
- ☐ Tuberculosis or respiratory disease ______
- ☐ COPD
- ☐ Cancer or tumor
  If yes, type and date ____________
- ☐ Fainting spells, seizures, or epilepsy
- ☐ Neurological condition ____________
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Dialysis
- ☐ Glaucoma
- ☐ Diabetes type ________
- ☐ AIDS or HIV positive
- ☐ Organ transplant
- ☐ Tobacco use If yes, circle smoke or smokeless
- ☐ Pre-medications required by physician
- ☐ Hospitalizations ______________

Do you have any condition not listed above?

____

____

Women:

- ☐ Pregnant or possibility of pregnancy
  Delivery date __________
- ☐ Nursing
- ☐ Taking hormones or contraceptives

Sleep: Do you experience any of the following?

- ☐ Diagnosed with sleep apnea or a sleep disorder
- ☐ Use a CPAP
- ☐ Snore or awake with shortness of breath
- ☐ Move excessively or shake in your sleep
- ☐ Have trouble falling or staying asleep
- ☐ Sleep or doze during normal daytime activities
- ☐ Wake up regularly without feeling refreshed

Allergies: Are you allergic to any of the following?

- ☐ Latex materials
- ☐ Penicillin
- ☐ Local anesthetics
- ☐ Narcotics ________________
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other __________________

Medications: Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics
- ☐ High blood pressure medication
- ☐ Antidepressants or tranquilizers
- ☐ Insulin or other diabetes drugs
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis medication
- ☐ Natural remedies
- ☐ Nonprescription drugs/supplements

Please list all current medications:

____

____

Patient/responsible party signature ____________________________ Date __________

Doctor signature ____________________________ Date __________

Financial Policy

Thank you for choosing Clocktower Family Dental for your dental care needs. The following information will explain our procedures and policies, which have been established so that we may serve you as promptly and efficiently as possible. Financial arrangements must be made prior to treatment.

- We are contracted providers (in-network) with Delta Dental Premier and coordinate out-of-network benefits with many other PPO policies. To further explore coverage of your unique plan at our office or to inquire about other in-house plans or payment programs, please discuss with a member of our front desk.
- Payment is due in full at the time of service for patients without dental insurance. Patients with insurance coverage are responsible for any deductible and estimated co-payments at the time of service.
- Third-party financing is available for patients requiring extensive treatment ($500 or more with approved credit). See our Treatment Coordinator for more details.
- In the event you would like to pay up front at the time of service in cash/guaranteed funds, we will not process a credit inquiry. However, when we bill insurance and accept assignment of future insurance and patient payments, we do reserve the right to run a brief credit inquiry in order to establish a history with the patient. With or without insurance, we do reserve the right to run a credit inquiry.

A Word About Dental Insurance

As a service to our patients, we will bill your insurance company. However, your insurance policy is a contract between you and your insurance company. Insurance policies vary, and services provided may not be covered. You are responsible for any fees that insurance does not pay.

Every insurance has different usual and customary fees that they pay, and when insurance says they pay 100% of cleanings, etc., it does not mean that 100% of our fee will be paid. The remaining balance is the responsibility of the patient. Recently we have noticed when patients have dual coverage, in some cases, the secondary insurance company will not pick up any or all of the remaining balance. Please refer to your insurance manual for specific coverage explanations. If your insurance has not paid within 60 days, we ask you to clear the balance within 15 days.

If you have any questions regarding treatment, fees, or services, please feel free to discuss them with us at any time. Provisions and policies contained in the agreement may change at any time and without prior written notice.

I understand and agree to abide by the financial policy.

____ ________________________

Signature of patient/responsible party Date

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I permit medical information to be shared with:

Name:	Relationship (spouse, partner, parent, guardian, etc.):
______________________________	____________________________
______________________________	____________________________
______________________________	____________________________

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 barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement.
- ☐ Other (please specify)

  ____

Cancellation Policy: At Clocktower Family Dental, we schedule our appointments so that each patient receives the right amount of time to be seen by our doctors and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time. We ask our patients to give us **48 hours** notice if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

- Standard business hours are considered Monday – Friday from 7:30 a.m. to 5:00 p.m. Any missed or failed hygiene (cleaning) appointments within these hours will be subject to a $50 cancellation fee for every hour booked.
- Failed restorative (doctor) appointments, and any appointments occurring during "prime times" (5:00 - 7:30 p.m. and Saturdays) are subject to a $75 cancellation fee for every hour booked.
- Fees associated with failed appointments are not reimbursable by your insurance company. You will be billed directly.
- A failed appointment is an appointment that is cancelled/rescheduled without 48 hours notice or an appointment where a patient does not show up.
- Patients that arrive more than 10 minutes late to their appointment will be considered no-shows and will be asked to reschedule.
- After three (3) failed appointments, we may require a deposit of up to 100% of your treatment total prior to scheduling, and our practice may choose to terminate its relationship with you.

Patient Conduct & Responsibilities:

All patients, staff members, and visitors in our office are expected to behave in a considerate and respectful manner.

- Patients will treat fellow patients and staff members with kindness, dignity, and respect.
- All patients will use respectful, appropriate language and behavior. Physical or verbal threats or assaults, suggestive or explicit words, phrases, gestures, or actions will not be tolerated.
- Patients have the responsibility to let a staff member know when they don't understand their treatment plan or cost associated with treatment.
- Patients have the responsibility to ensure that their bill is paid promptly.
- Patients have the responsibility to provide the most accurate and complete information related to their medical history, present complaints, insurance coverage, financial needs, etc.

By signing below, I signify that I understand and agree to the policies listed above.

____________________________________ ____________________

Patient Signature Date

Photo Release Form

I hereby grant permission to Clocktower Family Dental to use my image and likeness without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed, and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image.

By signing this release, I understand this permission signifies that photographs of me may be electronically displayed online or in printed materials. I will be consulted about the use of the photographs for any purpose other than those listed. This release applied only to photographs related to my relationship with Clocktower Family Dental as a dental patient.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to the stated terms. I hereby release any and all claims against any person within this organization utilizing this material for the purpose stated above.

Full Name____

Address____

City______________________________ State__________ Zip________________

Phone___________________________ Email______________________________

Signature____________________________________ Date________________

If this statement is obtained from a patient under the age of 18, then the signature of the patient's parent or legal guardian is also required.

Parent/Legal Guardian Signature____________________________Date______________