SPRING CREEK DENTAL

Patient Registration

Patient Name _____
Last First M.I.

If a child Name of guardian: _____
Last First M.I.

Relationship: _____

How do you wish to be addressed? _____

Residence Street Address _____

City_____State_____ZIP_____

Telephone: Home_____

Telephone: Cell _____

Telephone: Bus _____

email address: _____

Patient/Parent employer _____

Person responsible for account _____

Patient Social Security #_____

Driver' s license # _____

Other family members in this practice:

_____

Someone to notify in case of Emergency–Name and phone number:

_____

Dental Insurance 1st Coverage

Employee Name_____

Employee DOB _____

Social Security # _____

Employer _____

Name of Insurance Co. _____

Address_____

Telephone _____

Policy # _____

Group # _____

Dental Insurance 2nd Coverage

Employee Name_____

Employee DOB _____

Social Security # _____

Employer _____

Name of Insurance Co. _____

Address_____

Telephone _____

Policy # _____

Group # _____

I authorize payment of insurance benefits directly to the dentist of dental group otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less that the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

Patient or Guardian signature: _____Date_____

PATIENT NAME: _____

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EXPLANATION OF SERVICES AND CONSENT TO DENTAL CARE AND TREATMENT

Anesthesia: The use of local anesthesia is common in dentistry. I understand that although rare, there are potential risks associated with the use of local anesthesia. Some potential complications include: Infection, nerve damage, unexplained reactions and/or allergic/toxic reactions that could result in heart attack, seizure, stroke and/or death.

X-rays or Radiographic Treatments: I understand that assessment of my oral health or disease will require periodic radiographs. I authorize my doctor to use professional judgement to provide appropriate care.

Drugs and Medication: I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. I understand that certain medications my cause drowsiness and it is advisable not to drive or operate heavy equipment when using such drugs.

Fillings: I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during treatment. I understand that there are oftentimes temporary biting and thermal sensitivity associated with the placement of both composite (white) and amalgam (silver) fillings. I realize that fillings are rarely permanent and usually require periodic replacement.

Crowns and Bridges: I understand there is oftentimes temporary biting and thermal sensitivity associated with tooth preparation for a crown or a bridge. I further understand that I may be wearing temporary crowns that are prone to loosening and may need re-cementing. In the event the temporary crown is inadvertently loosened, I will notify my doctor of the occurrence so that it can be maintained until the final restoration is delivered. I understand that is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I also understand that although artificial, crowns and bridges need to be maintained with adequate oral hygiene to prevent future dental caries that would necessitate replacement.

Periodontal Disease: Periodontal disease is a serious, chronic inflammatory condition that left untreated, can cause inflammatory bony resorption resulting in loss of permanent teeth. I understand that my condition will be assessed and treatment that may or may not include the some or all of the following: deep cleaning, gum surgery,extraction and referral to a specialist will be explained to me. I further understand that the success of periodontal treatment depends on my adherence to following my doctor' s instruction, including strict observance of recall appointments.

Extractions: I acknowledge that alternatives to tooth removal include root canal therapy, extensive restorations (crowns) and periodontal treatments have been explained to me. I understand that complications from tooth extraction including dry socket, bony spur formation do occur and may require additional treatment.

Root Canal Treatment: I realize there is no guarantee that root canal treatment will save a tooth, and that complications can occur from treatment. In addition, there are a small percentage of root canal treatment procedures that fail despite optimal treatment. I understand in these particular situations a specialist may need to be consulted or the tooth may need to be extracted. Occasionally root canal filling material may extend through the end of the root, which may or may not effect the success of treatment. I understand that the instruments used to perform treatment are extremely fragile instruments and may sometimes separate within the root, which may or may not affect the success of the procedure.

Dentures: I understand that wearing dentures is not a simple process and may require significant time for adjustment. Common difficulties include sore spots, altered speech and difficulty eating. I understand that immediate dentures (placed immediately after extractions) may be quite uncomfortable for several days and may require frequent adjustments and one or more permanent relines.

Changes in Treatment Plans: I understand that during the course of treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I also understand that delaying recommended procedures may alter treatment significantly resulting in possibly more extensive and costlier treatment.

Patient Signature _____ Date: _____