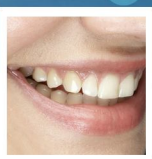
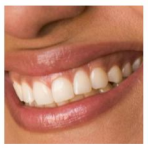
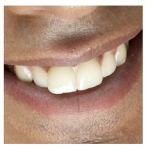
Crossoak Family Dentistry, P.C.
1299 M 89
Plainwell MI 49080

(269)685-1316
contactus@dentistry4cowards.com
www.dentistry4cowards.com

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Morning ☐ Afternoon
☐ Any time

Whom may we thank for referring you to our practice?

☐ Co-Worker ☐ Drive By ☐ Friend/Family ☐ Internet
☐ Phone Book ☐ Shoppers Guide ☐ Website ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

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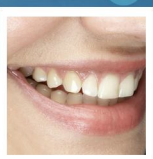
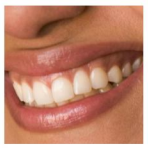
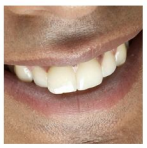

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS or HIV
- ☐ Allergies _____
- ☐ Allergy - Codeine
- ☐ Allergy - Keflex
- ☐ Allergy - Latex
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy - Topical
- ☐ Allergy-Tetracycline
- ☐ Alzheimers
- ☐ Anemia
- ☐ Art. Heart Valve
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Biphosphate
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cold Sores
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness
- ☐ Doxycycline
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Meniere's Disease
- ☐ Mental Disorders
- ☐ MitralValveProlapse
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Nervous Disorders
- ☐ Osteonecrosis
- ☐ Osteoporosis
- ☐ Other Disorders
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Premedicate
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ See Chart*
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Weak Bones Medicine

_____

☐ Other - please explain

*OFFICE USE ONLY

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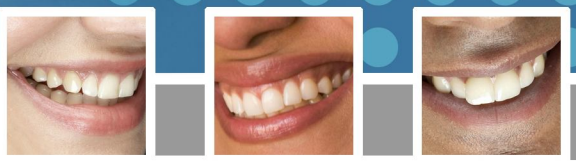

Have you ever had any complications following dental treatment? If yes, please explain:

◯ Yes ◯ No

Have you ever taken a biphosphate oral or IV medication for osteoporosis (weak bones) or cancer? Common medications include Fosamax, Boniva, Actonel, Skelid, or Didronel. If yes, please explain:

◯ Yes ◯ No

Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please explain:

◯ Yes ◯ No

Are you now under the care of a physician? If yes, please explain:

◯ Yes ◯ No

List any over the counter or prescription medications you are taking.

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.

Signature: _____ Date:

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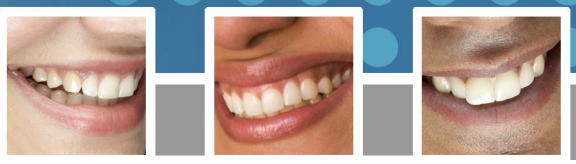

Person Responsible for Payment

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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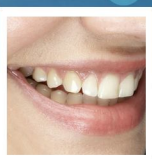
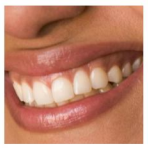
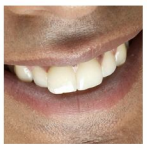

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ ____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ ____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ ____ _____

City State Zip Code

Primary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

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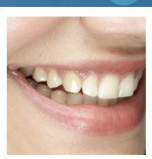
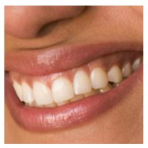
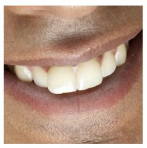

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____

City State Zip Code

Secondary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

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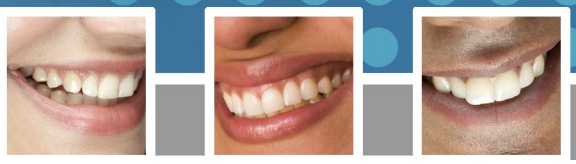

Consent for Services

As a condition of receiving dental care at this office, I agree to abide by the requirements of the Crossoak Family Dentistry, P.C. Patient Agreement. This includes prompt payment for services as they are rendered unless other agreements have been made in advance.
I realize that a service charge of 0.58% per month (7% per annum) will be charged on any unpaid balance after 30 days.
I understand that any pre-treatment dental care estimates given will only be honored for 12 months from the date they are initially quoted. If actual treatment needs turn out to be different from those estimated the fee will, of course, be adjusted up or down to reflect this.
In consideration for the professional services rendered to me, I agree to pay Crossoak Family Dentistry, P.C., either 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 cover all costs and reasonable attorney fees if my failure to pay leads to a suit or other collection action.

I grant my permission to Crossoak Family Dentistry P.C. or its assignee, to telephone me at home or at my work to discuss matters related to my dental care.

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

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____

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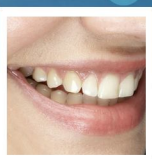
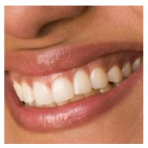
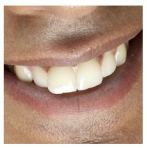

PRIVACY PRACTICES

Federal and State HIPAA laws require that after April 14th, 2003 all patients be informed of their dental offices particular privacy practices. We have instituted various safeguards and practices to protect your personal health information and especially focus on keeping confidential anything that might be sensitive (such as certain medical conditions you may have or financial problems).
In compliance with the HIPAA laws we are providing you with a formal notice of our privacy practices. This notice is also posted in our reception area. In the normal process of our daily operations we do need to disclose some information about you. For instance: 1) To remind you of upcoming dental appointments we mail reminder cards or call and leave messages at your home stating the date and time of your appointment; 2) To process your insurance claims we must tell your insurance company what treatment was done and the date; 3) We may be asked to discuss your care with concerned family members (such as a spouse, parent or guardian); 4) We may need to obtain a consultation from a specialist if your condition is complicated, requiring us to describe your specific situation. 5) In the event that your account became seriously overdue we might have to share what was owed with a collection agency. On the other hand, without your express consent we will not casually discuss or share your personal health information with anyone who does not have such legitimate rights and a need to know. If you have a specific privacy concern (such as not wanting us to share any of your information with a former spouse or employer) please let us know in writing and, if feasible, we will try to honor your request.

WE ABSOLUTELY WILL NOT RELEASE ANY INFORMATION ABOUT YOU TO ANY PERSON OR ORGANIZATION FOR THE PURPOSE OF ADVERTISING, MARKETING OR SOLICITING.

I have read this sheet and received (or was offered) a copy of your privacy practices. Until I notify you otherwise*, I give you permission to share my dental, general health and financial information with my insurance company, family, specialists, and others in those circumstance you deem necessary or appropriate. I understand and expect that you will exercise discretion and care in protecting confidential matters and will never release my information for marketing.**

Signature: _____ Date: _____

*Or this agreement expires according to any HIPAA limitations on such agreements
**You may revoke this consent at any time by submitting written notice

Response Date: _____

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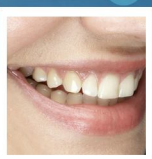
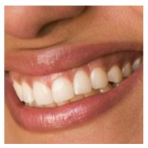
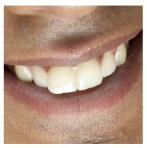

Written Financial Policy

Thank you for choosing Crossoak Family Dentistry, PC. Our primary mission is to deliver high quality dental care in a nonthreatening, comfortable setting. An important part of this mission is making the cost of quality care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS:

You can choose from:

☐ Cash ☐ Visa ☐ MasterCard ☐ Discover ☐ CareCredit

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash, check, Visa, Mastercard, or Discover.

Convenient Monthly Payment Plans* from CareCredit

- Allow you to pay over time with low or no interest

- No annual fees or pre-payment penalties

PLEASE NOTE:

When using CareCredit to finance your treatment we usually require payment prior to the completion of your treatment. If you choose to discontinue care before all planned treatment is complete, you will receive a refund less the cost of the care already received. *Using CareCredit is subject to credit approval.

Dental care involving lab fees (crowns, dentures, etc.) must be paid in full by the delivery date.

We also offer short term (3-4 months) in-house financing for patients in good standing. Payments are due by the 15th of each month (annual interest rate of 7% charged each month). If payment is not received within 10 days of the due date it is the office policy to assign a late charge of $5.00 to the balance.

There is a $35 charge for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dental care you want or need. I have read and agree to comply with the offices financial policies.

Signature: _____ Date: _____

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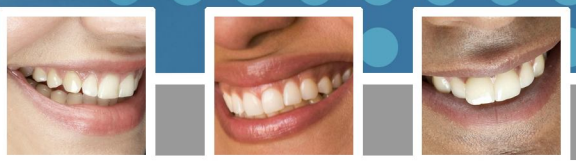

FOR PATIENTS WITH DENTAL INSURANCE:

Many of our patients are fortunate enough to have some form of dental insurance. This is a contract between the patient, their employer, and an insurance company to pay a certain amount for certain dental services under certain circumstances. Sound kind of vague and confusing? It is! There are literally thousands of different insurance plans and they have many different levels of coverage, different conditions for coverage, different annual deductibles, different annual maximums, and different exclusions. And each plan changes almost every year! If you tell us you have Delta or Blue Cross or Aetna or Metropolitan that doesnt tell us the details of your plan---each company offers many different plans to employers, based on the premiums they are willing to pay. The better dental plan covers more services at higher rates and offers patients more flexibility on where they can go to receive treatment.

Although our office staff will try to answer any questions you may have, we do not and cannot know all the changing details of each dental insurance plan. That is the responsibility of your plan administrator at the place where you work. We will provide a good faith ESTIMATE for you on the amount we anticipate your insurance will pay and ask that you pay the difference at the time of treatment. Then, after your insurance pays, we will refund, credit or bill to you any difference. As a service to our patients we are willing to fill out and submit copies of any treatment you have done to your insurance company for you, but we cannot guarantee how much or even if they will pay for it. Whatever they do NOT pay is your responsibility.

Some dental insurance companies give their employees a limited list of providers (dentists) with which they have negotiated special discounts. They offer these dentists the opportunity to be on a preferred provider list in exchange for reduced pricing or limiting the services they can offer. This generally appeals primarily to those dentists who have difficulty otherwise staying busy and attracting or keeping patients---most dentists are not participating. If your dental plan in any way restricts who you may see or pays more only if you see certain participating dentists please be informed that we are NOT on any such lists or participating with any such plans. Usually, but not always, such plans will allow patients to see non-participating dentists but will pay at a reduced rate if they do so. Some plans will not pay at all. We have many patients with such plans who have elected to receive their dental care from us despite this. If you have such a restricted dental plan, and getting the maximum possible payments from your insurance is very important to you, you may decide to go elsewhere. We will be happy to make recommendations for you from any lists of dentists you may have.

We will do our best to get you the most coverage from your insurance we can. Sometimes it is helpful for you to directly call your insurance company if they have rejected a claim for frivolous reasons or paid poorly. We will give you contact information in such cases. It is also good to be aware that all dental insurances have relatively low maximum amounts they will pay annually (generally between $500-$2000) and some also have deductibles that must be satisfied before they begin paying. Some will pay a higher percentage for one type of filling than another. Some have exclusions for services such as bite splints or orthodontics (braces). If there is an elective dental treatment you are interested in but would only want to receive if you are certain your insurance will cover it, you can request for us to submit a pretreatment estimate to your insurance company. This will delay care 4-8 weeks but provides a better estimate what they will pay.

If you have any questions, please do not hesitate to ask. We are here to help you get the dental care you want or need. I have read and agree to comply with the offices financial policies.

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____