TrailheadDental
Implants and Prosthodontics

TODAY'S DATE: _____

_____

Patient Name

Gender: M F **Marital Status: Single Married Widowed**

_____

Social Security Number **Birth Date**

_____

Mailing Address

_____

City **State** **Zip Code**

_____

Home Phone **Cell Phone**

_____

Employer **Occupation**

_____

E-mail **Would it be OK to contact you by E-mail or Text? Yes No**

Whom may we thank for referring you to our office? _____

_____

General Dentist

_____

Office Phone Number **Last Cleaning**

In the event of an emergency, please contact:

Name_____ Relationship_____ Phone_____

TrailheadDental
Implants and Prosthodontics

FINANCIAL POLICY

Thank you for choosing Trailhead Dental, where our primary goal is delivering the best dental care available. An important part of that mission is making the cost of treatment as easy and as manageable as possible. To do this, we offer several payment options:

- Cash, Check, Visa®, MasterCard®, or Discover Card®
    - We offer a discount to patients who pre-pay for their treatment with Cash, Credit Card or Check (plans of $10,000.00 or more).
    - Please note that we impose a surcharge of 3% on the total transaction amount on credit card products, which is not greater than our cost of acceptance. There are no surcharges for using debit cards.
    - Trailhead Dental charges $35.00 for returned checks.

- Monthly Payment Options from Care Credit Healthcare Credit Card and The Lending Club Financial Institute.
    - Allows you to spread payments over time
    - No annual fees or pre-payment penalties

Insurance and Financial Arrangements

We require that you pay for your initial visit at the time this service is rendered. It is our office policy to not carry balances. Payment is expected as your treatment is provided. Our initial exam fee is $250.00 - $750.00. Radiographs are an essential part in the diagnostic process, and hence Trailhead Dental does not charge for x-rays. However, if you request duplication of your records, there is a $75 fee (we will export all of your x-rays onto a USB thumb drive).

Trailhead Dental does not render treatment under the assumption that charges will be by an insurance company. For patients with dental insurance, we will work to help you maximize your benefits and we can provide you with a completed dental insurance claim for you to send to your insurance company. It is your responsibility to follow up with your insurance company to ensure you receive any insurance reimbursement, as we do not accept payment from the insurance companies. If an insurance payment is sent to Trailhead Dental, this payment will be returned directly to the insurance company.

Unfortunately, our dental practice management software is unable to provide your medical insurance the necessary information that is required to file medical insurance claims.

Our Cancellation Policy

Please note that once you have booked an appointment with us, it means that we have reserved time in our schedule exclusively for you. If you cancel your reserved appointment time less than 48 business hours before it is scheduled to take place, you will be subject to a fee of $75.00.

Terms and Conditions

I understand that if a debt is to be collected, my credit history may be checked using my Social Security number or other information I have provided. I agree that this office, or an assignee, may contact me by phone at my home or workplace to discuss matters related to this form or any related legal proceedings. I have read and understand the above conditions and agree to them.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient Signature / Parent or Guardian Signature Date

TrailheadDental
Implants and Prosthodontics

Health History

Primary Reason for Visit:

_____

_____

Current Dental Problems (check all that apply):

Tooth Pain	Yes	No	Clenching/Grinding	Yes	No
Missing Teeth	Yes	No	Jaw Clicking/Popping	Yes	No
Bleeding Gums	Yes	No	Jaw Joint Pain	Yes	No
Loose Teeth	Yes	No	Jaw Locking	Yes	No
Gum Recession	Yes	No	Dry Mouth	Yes	No
Periodontal Disease	Yes	No	Oral Cancer	Yes	No
Cavities	Yes	No	Cancer of Head/Neck	Yes	No
Abscesses	Yes	No	Difficulty Chewing	Yes	No
Broken Teeth	Yes	No	Difficulty Speaking	Yes	No
Worn Teeth	Yes	No	Broken Denture/Partial	Yes	No
Sores in Mouth	Yes	No	Broken Crown (Cap)	Yes	No
			Broken Filling	Yes	No

Other problem/condition not listed (described):_____

_____

Do you like the appearance of your smile? Yes No

Current Medical Problems (check all that apply):

Headaches	Yes	No	Heart Attack	Yes	No
Sinusitis	Yes	No	Stroke	Yes	No
Ear Infection(s)	Yes	No	Congestive Heart Failure	Yes	No
Impaired Vision	Yes	No	Cardiovascular Disease	Yes	No
Glaucoma/ Cataracts	Yes	No	High Blood Pressure	Yes	No
Impaired Hearing	Yes	No	COPD/ Emphysema	Yes	No
Acid Reflux/ GERD	Yes	No	Asthma	Yes	No
Sleep Apnea	Yes	No	Joint Replacement	Yes	No
Seizures/Epilepsy	Yes	No	Osteoporosis	Yes	No
Depression	Yes	No	Diabetes	Yes	No
Anxiety	Yes	No	Hypo-/ Hyperthyroid	Yes	No
Alcohol/Drug Abuse	Yes	No	Kidney Failure	Yes	No
Eating Disorder(s)	Yes	No	Liver Disease/ Cirrhosis	Yes	No
Bipolar Disorder	Yes	No	Hepatitis B/C	Yes	No
Anemia	Yes	No	Tuberculosis	Yes	No
Bleeding Disorders	Yes	No	HIV-AIDS	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No

Do you have any medical conditions/problems not listed above (describe): _____
_____
_____

Women Only

Are you pregnant or considering becoming pregnant? Yes No
Are you nursing? Yes No

Medications/ Supplements (List All)

Medication/Supplement Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*If necessary, please attach separate sheet

Are you or have you ever taken Bisphosphonates? Yes No

Allergies

Penicillin/Amoxicillin	Yes	No	Ibuprofen	Yes	No
Cephalosporin	Yes	No	Acetaminophen	Yes	No
Sulfa	Yes	No	Naproxen Sodium	Yes	No
Clindamycin	Yes	No	Latex	Yes	No
Codeine	Yes	No	Nickel	Yes	No
Oxycodone	Yes	No	Gold	Yes	No
Hydrocodone	Yes	No	Cobalt/ Cobalt Chrome	Yes	No

Other allergies not listed above:_____

Habits

Are you currently a smoker Yes No
Are you a former smoker Yes No
Do you use smokeless tobacco Yes No

Do you drink alcohol every week? Yes No
Do you use recreational drugs Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

_____

Patient Signature / Parent or Guardian Signature Date

TrailheadDental
Implants and Prosthodontics

General Consent

Diagnostic Procedures

The first step in dental care is the diagnosis of current problems. In order to do this, Dr. Leong may perform the following diagnostic that include, but are not limited to: (1) a medical and dental history, (2) a clinical examination, (3) dental X-rays, (4) digital dental impressions/ molds of the teeth, (5) photographs, and (6) communication with previous or concurrent healthcare professionals.

I understand that honest disclosure of existing medical/dental conditions, current medications and supplements, as well as the contact information for previous or current healthcare providers is necessary for accurate diagnosis and planning. I understand that failing disclose this information may compromise the success of my dental treatment.

Initial_____

I understand that will I be receiving a dental examination from a state licensed dental practitioner. I understand that X-rays will be taken of my teeth and jaws, and that I will be exposed to a minimal amount of radiation as a part of the necessary requirements to complete a comprehensive examination. I also understand that if I am pregnant, radiation exposure possesses a serious risk to the health of the fetus, and that pregnant women are required to have a medical release prior to X-rays.

Initial_____

Treatment Recommendations and Progress

Treatment recommendations are based upon the diagnostic information gathered, as well as the experience and opinion of Dr. Austin Leong. Unfortunately, it may not be possible to determine the full extent of a problem until treatment has begun. This may require changes to the original treatment recommendations, and therefore a change in cost. Further, delays in treatment or missed appointments may lead to problems with timing of treatment that increase the overall cost of treatment.

I understand that during the course of treatment it may be necessary to modify the procedures outlined in my treatment plan because of unforeseen conditions, unexpected events, or new conditions. I understand that this may impact the timing and cost of my treatment.

Initial_____

Use of Records for Educational Purposes

I authorize the use my dental records, which includes, diagnostic information, photos, X-rays, and dental models for educational purposes.

Initial_____

Dismissal

Our goal is for every patient to have an exceptional experience at Trailhead Dental. However, in very rare situations it may be necessary to end the patient-doctor relationship prior to completion of care.

I understand that failing to disclose important health information, repeatedly missing appointments, failing to comply with clinical recommendations, or exhibiting hostile/aggressive behavior may result in dismissal from Trailhead Dental.

Initial_____

Treatment Outcome/ Warranty

Due to the complexity of prosthodontic treatment and the individual differences between patients, it is not possible to guarantee specific results. However, every reasonable effort will be made to treat your dental conditions successfully. If complications occur after the completion of treatment, they will be addressed on a case-by-case basis. The policy of Trailhead Dental is to the cover costs associated with material failures/ fractures that occur within 2 years of treatment completion; however, this is contingent upon patient compliance with recommended follow up care. Further, patients who undergo treatment at outside dental offices after completion of their care at Trailhead Dental forfeit any warranty.

I hereby acknowledge that no promise has been given to me that the proposed treatment will be successful. I acknowledge that I am responsible for payment of all dental fees, regardless of outcome and/or dental insurance coverage.

Patient Signature / Parent or Guardian Signature Date

TrailheadDental
Implants and Prosthodontics

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)

_____

_____

_____

TrailheadDental
Implants and Prosthodontics

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Trailhead Head Dental to release my records and any information requested to the following individuals.

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____
4. _____ Relationship to Patient: _____

Authorization Regarding Messages

(Please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ Messages may only be left with _____

_____
Print Patient Name

_____
Patient Signature / Parent or Guardian Signature Date