



1717 East 66th Street
Richfield, MN 55423
612-861-7109

PATIENT INFORMATION

Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security Number: _____ Male Female
Month Day Year

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail: _____ Occupation: _____

Marital Status: Married Single Minor

Emergency Contact: _____
Name Phone # Relationship

Primary Dental Benefits: _____ ID #: _____ Group #: _____

Policy Holder Name: _____ Relationship: _____

Policy Holder's Social Security #: _____ Policy Holder's DOB: _____

Phone #: _____ Employer of Policy Holder: _____

Secondary Dental Benefits: _____ ID #: _____ Group #: _____

Policy Holder Name: _____ Relationship: _____ Employer: _____

Policy Holder's Social Security #: _____ Policy Holder's DOB: _____ Phone #: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Your May Refuse to Sign This Acknowledgement

I have received or had full opportunity to read a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

Authorization: I agree that the dental practice may communicate with me electronically at the e-mail address listed. I am aware that there is some level of risk that third parties might be able to read unencrypted e-mails. I am responsible for providing the dental practice any updates to my e-mail address. I can withdraw my consent to electronic communications by calling: 612-861-7109.

Authorization: I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

Patient/Responsible Party Name: _____

Patient/Responsible Party Signature: _____ **Date:** _____



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FINANCIAL MENU

Dental Health Care Center offers a wide range of financial options in order to pay for your dental treatment.

A. Cash Account

If you do not have insurance, payment in full is expected at the time of service. A 5% bookkeeping allowance will be given for direct payment in full by cash or check at your visit. We also accept payment by credit or debit card but no bookkeeping allowance will be given when using this form of payment.

B. Dental Benefits

DHCC participates in a variety of benefit plans and will file the necessary forms for payment, however, we assume no responsibility for payment by any third party. Your estimated patient responsibility is due at the time of service, any unpaid balances after the claims are processed are subject to a finance charge.

C. CareCredit

With fast, on-line approval, CareCredit financing can help you get the dental care you've always needed or wanted with the financing designed specifically for you. CareCredit allows you to start treatment immediately and offers deferred interest, low monthly payments, no up-front costs, no pre-payment penalties, and no annual fees.

I have read and understand the above Financial Menu.

Responsible Party Name (Print): _____

Responsible Party Signature: _____ **Date:** _____

OPTIONAL

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best care possible, you may choose from any of the following: Cash, Checks, Money Order, Visa, MasterCard, Discover, or CareCredit.

If I do not pay the entire new balance within 30 days of the monthly billing date, a finance charge will be added to the account for the current monthly billing period. Unpaid balances are subject to a finance charge.

We will do our best to estimate your patient responsibility, however, after your dental benefits have processed the claim for the dental services rendered at DHCC, you may have an outstanding balance. For balances owed, we ask that you leave a credit card on file. If requested, we will mail you your account receipt and transaction slip to the address on file.

Patient Name: _____

Credit Card (check one): Visa MasterCard Discover CareCredit **NOT TO EXCEED:** _____

Card #: _____ Exp Date: _____ Sig. Code: _____

Card Holder Name (print): _____

Card Holder Signature: _____

Billing Address: _____ State: _____ Zip: _____

Receipt Requested: Yes, e-mail Yes, mail No

I hereby authorize Dental Health Care Center to process payments from time to time, as the office deems necessary, to settle my account in full. The agreement is considered valid until written notification is received. I certify that I have read, fully understand, and accept the above financial policy.



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**INFORMED CONSENT
PHOTOGRAPHS, X-RAYS, RECORDS**

I understand that photographs, x-rays, and other records may be necessary during the course of my examination, treatment, and follow-up care. I give my permission for such items to be used for purposes of research, education, promotional materials, or publications in professional journals.

I do not give permission for my records to be used

COMPOSITE RESTORATIONS

At Dental Health Care Center direct placed restorations are composite resins. We believe they are the most esthetic, and function superior to amalgam (mercury/silver).

Please read the following information concerning composite restorations:

1. My direct placed restoration will be done as a bonded resin-composite unless otherwise noted.
2. My dental benefits may or may not cover the cost of this restoration, substituting payment for an amalgam restoration instead.
3. I am responsible for any difference in fee between an amalgam and composite restoration.

CANCELLATION POLICY

When we make your appointment, we are reserving a room especially for your particular needs. We ask that if you must change an appointment, please give us at least 2 BUSINESS DAYS notice. This courtesy makes it possible to give your reserved room to another patient in need. There is a \$75 charge for not showing up for scheduled appointments, or for cancelling an appointment without sufficient notice. Repeat cancellations or missed appointments will result in the loss of future appointment privileges.

I have read the above and understand the information concerning photos, x-rays, records, restorations, and the cancellation policy.

Patient Name _____

Signature: _____ **Date:** _____

Please let us know why you chose DHCC for your care 😊

How did you learn about our practice? _____

Why did you choose us? _____

Did you use the internet in your search? YES / NO Directory Used Search Terms? _____

Were you referred by a family member, friend, or co-worker? (please circle) Name: _____



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Consent to Share Confidential Medical & Dental Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patients Legal Name: _____ Date of Birth: _____

I HEREBY AUTHORIZE DENTAL HEALTH CARE CENTER TO SHARE:

- _____ My appointment times, dates, and reasons for the visits
- _____ The medications I am taking/have taken
- _____ The following information (specify): _____

WITH THE FOLLOWING PEOPLE:

Full name: _____ Relationship: _____

Full name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to DHCC), but that canceling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical/dental provider or my clinic to share information with someone.

Name: _____

Signature: _____ Date: _____

Relationship to patient: _____

If you are not the minor patient's parent, you must provide proof of guardianship (i.e. court order or power of attorney).

General Consent to Treatment of a Minor

Please fill out if patient is under 18 years of age

Patient: _____ Date of Birth: _____

I authorize Dental Health Care Center (DHCC), its dentists and members of its team, to provide such regular dental care including cleaning, x-rays, and fluoride to the minor as is necessary for the minor's health and best interests, or as in your judgment is advisable. This authorization includes but is not limited to authorization for DHCC dentists to perform specific procedures including extractions and restorative procedures. I authorize DHCC, its dentist and members or its team to act on my behalf in case the minor is a victim of major accident, injury or illness when immediate dental or surgical care is needed, provided diligent effort is made to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize DHCC, its dentists or members or its team to take such action and give such consent on my behalf as their judgment dictates. I acknowledge that DHCC deems it advisable that an authorized adult accompany the minor to the clinic for examination and treatment. I agree to cooperate by being present at all times possible or when requested.

1. Responsible Party: _____ Phone #: _____ DOB: _____

Address: _____ Relationship: _____

2. Responsible Party: _____ Phone #: _____ DOB: _____

Address: _____ Relationship: _____

Guardian's Name: _____ Relationship to minor: _____

Signature: _____ Date: _____

If you are not the minor patient's parent, you must provide proof of guardianship (i.e. court order or power of attorney).