CRABTREE VALLEY
DENTAL

Welcome to our Practice!

As our mission statement says, our purpose is to truly serve you as we meet your needs and exceed your expectations. Our values are assurance, humble service, genuine compassion, and courteous efficiency. We have the utmost respect for you and are humbled that you chose us.

Appointments

Our appointment system is designed so that we may give the most efficient care in a pleasant and relaxed environment. We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We make every effort to call our patients as a reminder for an appointment. You will receive a reminder 2-3 days prior to your appointment. Patients are kindly asked to confirm at least 24 hours prior to the scheduled appointment. Appointments can be confirmed by responding within the electronic notification, calling the office, or on the website contact page.

Continuing Care

This practice is centered on prevention and optimum oral health. We discourage isolated, occasional treatment and recommend comprehensive treatment, continuing care and regular maintenance.

After Hours Emergency Care

Our practice provides 24 hour support for our patients of record. A patient of record has been seen and received treatment in the office within the last 18 months. If you are a patient of record in need of emergency dental care and it is after hours, you may call the office number and one of our Team Members will contact our doctors.

Cancellation & Missed Appointments

We require a minimum of twenty-four (24) hours advance notice of cancellation. Patients who do not provide twenty-four (24) hour notice of cancellation or do not present for a scheduled appointment will have a $50 fee assessed per instance and risk not having a timely appointment.

Children & Adolescents

We provide children with the same care that our adult patients receive and prefer to care for them as individuals. Parents may accompany children in the operatory by invitation only. We require that parents/legal guardian **remain in the building** with minor children (under 18 years of age) for the entire appointment.

Education

An abundance of educational material is available in the office and on our website, **www.crabtreevalleydental.com** for your review. We will provide specific information as it relates to your dental needs. We welcome your questions about any dental products, services, or technology.

Technology

Digital radiography, intra-oral photography and Patient Education software are examples of the state of the art technology used in our office for diagnosis and treatment planning. Our patients appreciate the efficiency and accuracy of this technology and like being involved in the decision-making process.

Sterilization

Rest assured we follow all recommended sterilization procedures and are compliant with all OSHA regulations

Investing in Your Dental Health

New studies have shown that investing in your oral health, in terms of both prevention and treatment, is not only good for function and aesthetics, but for overall health as well. More recently, the bacteria that causes periodontitis has been linked to an increase in cardiovascular disease. We endeavor to provide our patients with the highest standard of care at an affordable price.

Payments & Insurance

Fees for services are due at the time treatment is rendered. Payment may be made in cash, check, or by credit card. We also offer third party financing. As a courtesy to our patients with dental insurance, we will make a good faith estimate of your benefits and file the appropriate claim forms.

Print Patient Name _____ Patient Signature _____

Date _____

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Welcome!

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)

HOW DID YOU HEAR ABOUT US? _____

EMAIL _____ MOBILE PHONE _____

WHICH FORM OF COMMUNICATION DO YOU PREFER? (Circle One); PHONE CALL / TEXT MESSAGE / EMAIL

SOCIAL SECURITY # _____ DATE OF BIRTH _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER: _____ WORK PHONE _____ EXT _____

RELATIONSHIP TO INSURANCE SUBSCRIBER (The person in your family who your insurance is through): Self Spouse Child Other

RESPONSIBLE PARTY FOR MINOR-

NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ DATE OF BIRTH _____

MARITAL STATUS: Married Single Other WORK PHONE _____ EXT _____

EMPLOYER _____ EMPLOYMENT ADDRESS _____

CONSENT:

1. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**: By signing below I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities, and health care operations as set forth in this office's Privacy Notice.
   AUTHORIZATION TO DISCLOSE: Additional Name(s) with whom we can discuss treatment and/or account information.
   Name: _____ **Phone #:** _____
2. I hereby authorize Crabtree Valley Dental designated staff to take X-rays, photographs and any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Crabtree Valley Dental to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary.
3. **I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Crabtree Valley Dental. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the Crabtree Valley Dental has a contractual agreement with my plan prohibiting all or a portion of such charges**.
4. By signing below, **I certify that I read and write English and I have read, fully understand, and agree to the above items**.

Patient/Guardian's Signature _____ **Date** _____

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General Dental Informed Consent Form

Crabtree Valley Dental would like to inform all patients of the risks and benefits of various dental procedures. Please review the following procedures and feel free to ask any questions. A treatment plan for all restorative needs, which includes **estimated** fees and treatment specific authorization will be presented to you for your review and your signature at the time the treatment plan is diagnosed.

☐ **Drugs and Medication:** Antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Risk of local anesthesia may include temporary or permanent numbness, swelling, pain and bruising at the injection site. It is my obligation to let the dentist know all of my medical conditions, medications and allergies to help avoid any adverse reactions.
_____ (initials)

☐ **Changes in treatment:** during treatment, it may be necessary to change, omit, or add procedures because of conditions discovered while working on the teeth that were not evident during the examination. For example, root canal therapy following routine restorative procedures. I give my permission to the doctor to make any changes or additions as necessary.
_____ (initials)

- **Extractions:** alternatives will be explained to me (root canal therapy, crowns and periodontal surgery...etc.). The removal of teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. Some risks are pain, swelling, spread of infection, jaw fracture, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
- **Crowns and bridges:** sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I may wear temporary crowns, which may come off easily. If a temporary crown dislodges, I understand the need to contact my doctor. It can be aspirated or ingested requiring immediate medical attention. If my temporary dislodges, I will contact my dentist so that it can be replaced. I will need to be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes in my new crown/bridge (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown/bridge. I understand there will be additional charges for remakes due to my delaying cementation.
- **Partials:** They are artificial, constructed of acrylic, metal and/or porcelain and are not anchored to bone like natural teeth. The potential consequences of wearing these appliances include loosening of abutment teeth, soreness, tooth loss and possible fracture of the appliance. Most partials require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial fee. I also understand that if I do not wear my partials at least 6 hours/day, my teeth will shift and the partial will no longer fit, necessitating a new partial.
- **Dentures:** I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed. A new set of dentures are often needed after the healing phase of 2 months. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be an additional charge.
- **Endodontic Treatment (Root Canal):** there is no guarantee that root canal treatment will save a tooth. Complications may occur during treatment which include file separation and perforation of the tooth which may compromise the prognosis of the tooth. Additional surgical procedures may be necessary following root canal treatment (apicoectomy) to help save the tooth but occasionally, the tooth will need to be extracted despite all efforts to save it.

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- **Periodontal Disease:** This is an active infection of the gums and supporting bone that leads to many unhealthy conditions including but not limited to tooth loss, pain, acute infection, swelling and systemic infection. Treatment will be recommended by the dentist explained. Depending on the severity of the disease, a referral to a specialist may be required.
- **Implants:** They are an alternative to bridges, partials or dentures. This process may involve the participation of an oral surgeon or periodontist. Fees for his/her services are separate from those of Crabtree Valley Dental. This process involves several steps and could require up to one year to complete. As with crowns, color may not match perfectly with natural teeth.
- **Sealants:** Although they form a hard shield that helps keep food and bacteria from getting into tiny grooves and causing decay along the chewing surfaces of the teeth, there is no guarantee that a sealant will prevent cavities. Occasionally sealants need to be replaced because they do not last a lifetime. We do, however, warranty our sealants for 18 months, granted that the patient is seen twice/year for prophylaxis visits. Sealants can be done at any age as long as the teeth are free of decay and fillings. The doctor will determine the best time to have them done.
- **Sedative fillings:** Sedative fillings are temporary. They are placed if inadequate anesthesia is obtained or the dentist wants to monitor the tooth after the decay has been removed prior to placing permanent restoration or a pulpal exposure has occurred necessitating a root canal or extraction. If a sedative filling dislodges, I understand the need to contact my doctor. It can be aspirated or ingested requiring immediate medical attention. If a sedative dislodges, I will contact my dentist so that it can be replaced.
- **Restorative:** I understand that any time a restoration is performed, there is a possibility of trauma to the nerve of the tooth, which could result in varying degrees of sensitivity and complications including but not limited to the following: cold sensitivity, hot sensitivity, sensitivity when flossing, biting sensitivity, abscess formation, pulp necrosis (when the nerve dies in the tooth) and pain. Most of the symptoms usually resolve as the nerve heals. I will contact Crabtree Valley Dental if any signs or symptoms present. Complications may arise resulting in the need for additional treatment, including one or more bite adjustments, replacement of the restoration due to open margins discovered after final cementation, root canal treatment or tooth removal.

By signing below I acknowledge that I have carefully read the above informed consent and fully understand all risks as it relates to my case.

Print Patient Name: _____

Signature of Patient / Parent / Guardian: _____

Date: _____

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Patient Medical History

Name _____

Are you under a physician's care now? OYes ONo If yes _____

Have you ever been hospitalized or had a major operation? OYes ONo If yes _____

Have you ever had a serious head or neck injury? OYes ONo If yes _____

Are you taking any medications, pills, or drugs? OYes ONo If yes _____

Do you take, or have you taken, Phen-Fen or Redux? OYes ONo If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? OYes ONo If yes _____

Are you on a special diet? OYes ONo If yes _____

Do you use tobaccos? OYes ONo If yes _____

Do you use controlled substances? OYes ONo If yes _____

Women: Are you...
Pregnant/Trying to get pregnant? Y / N Nursing? Y / N Taking oral contraceptives? Y / N

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Sulfa Drugs O Local Anesthetics O Other _____

AIDS/HIV Positive	OYes	ONo	Cortisone Medicine	OYes	ONo	Hemophilia	OYes	ONo	Radiation Treatments	OYes	ONo
Alzheimer's Disease	OYes	ONo	Diabetes	OYes	ONo	Hepatitis A	OYes	ONo	Recent Weight Loss	OYes	ONo
Anaphylaxis	OYes	ONo	Drug Addiction	OYes	ONo	Hepatitis B or C	OYes	ONo	Renal Dialysis	OYes	ONo
Anemia	OYes	ONo	Easily Winded	OYes	ONo	Herpes	OYes	ONo	Rheumatic Fever	OYes	ONo
Angina	OYes	ONo	Emphysema	OYes	ONo	High Blood Pressure	OYes	ONo	Rheumatism	OYes	ONo
Arthritis/Gout	OYes	ONo	Epilepsy or Seizures	OYes	ONo	High Cholesterol	OYes	ONo	Scarlet Fever	OYes	ONo
Artifical Heart Valve	OYes	ONo	Excessive Bleeding	OYes	ONo	Hives or Rash	OYes	ONo	Sinus Trouble	OYes	ONo
Artificial Joint	OYes	ONo	Excessive Thirst	OYes	ONo	Hypoglycemia	OYes	ONo	Sickle Cell Disease	OYes	ONo
Asthma	OYes	ONo	Fainting/Dizziness	OYes	ONo	Irregular Heartbeat	OYes	ONo	Spina Bifida	OYes	ONo
Blood Disease	OYes	ONo	Frequent Cough	OYes	ONo	Kidney Problems	OYes	ONo	Stomach/Intestinal Disease	OYes	ONo
Blood Transfusion	OYes	ONo	Frequent Diarrhea	OYes	ONo	Leukemia	OYes	ONo	Stroke	OYes	ONo
Breathing Problems	OYes	ONo	Frequent Headache	OYes	ONo	Liver Disease	OYes	ONo	Swelling of Limbs	OYes	ONo
Bruise Easily	OYes	ONo	Genital Herpes	OYes	ONo	Low Blood Pressure	OYes	ONo	Thyroid Disease	OYes	ONo
Cancer	OYes	ONo	Glaucoma	OYes	ONo	Lung Disease	OYes	ONo	Tonsillitis	OYes	ONo
Chemotherapy	OYes	ONo	Hay Fever	OYes	ONo	Mitral Valve Prolapse	OYes	ONo	Tuberculosis	OYes	ONo
Chest Pains	OYes	ONo	Heart Attack/Failure	OYes	ONo	Osteoporosis	OYes	ONo	Tumors or Growths	OYes	ONo
Cold Sores/Fever Blisters	OYes	ONo	Heart Murmur	OYes	ONo	Pain in Jaw Joints	OYes	ONo	Ulcers	OYes	ONo
Congenital Heart Disorder	OYes	ONo	Heart Pacemaker	OYes	ONo	Parathyroid Disease	OYes	ONo	Venereal Disease	OYes	ONo
Convulsions	OYes	ONo	Heart Trouble/Disease	OYes	ONo	Psychiatric Care	OYes	ONo	Yellow Jaundice	OYes	ONo

Have you ever had any serious illness not listed OYes ONo If Yes _____

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge.

Patient Signature: _____ Date: _____
(Parent/legal guardian signature for patients under 18)
(POA Signature)

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Patient Dental History

Name _____

When was the last time you visited the dentist? _____ Where? _____

When was the last time you had your teeth cleaned? _____

Do you usually see the dentist every six (6) months?		OYes ONo
Do you have Fluoride in your drinking water?		OYes ONo
Have you had periodontal (gum) treatment?		OYes ONo
Have you ever had orthodontic treatment (braces?)		OYes ONo
Do you floss regularly?		OYes ONo
Do your gums bleed when you floss?		OYes ONo
Do you have any ulcers, cold sores or growth on lips or mouth?		OYes ONo
Do you have difficulty swallowing?		OYes ONo
Do you have clicking or popping in your jaw?		OYes ONo
Do you have Jaw Fatigue or pain?		OYes ONo
Do you have dry mouth?		OYes ONo
Do you Clench, Grind or have morning headaches?		OYes ONo
Have you been diagnosed with sleep apnea or do you use a CPAP?		OYes ONo
What kind of toothbrush do you use?	Hard _____ Medium _____ Soft _____ Electric _____	
Do you have sensitivity to:	Cold _____ Hot _____ Sweet _____ or Biting Pressure _____	
Do you wear:	Retainers _____ Night Guard _____ or another oral appliance _____	

Please rate your smile on a scale from 1-10 (1=unhappy; 10=very happy) _____

If you could change your smile in one way, what would you change? _____

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge.

Patient Signature: _____ Date: _____

(Parent/legal guardian signature for patients under 18)

(POA Signature)

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Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Crabtree Valley Dental **is authorized to release protected health information about the above named patient in the following manner and to identified persons.**

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	List all numbers: _____ , _____
☐ Other person (s) **(provide name and phone number)** _____	☐ Financial ☐ Medical ☐ Dental
☐ Email Communication-Provide email address below* _____	☐ Financial ☐ Medical / Dental ☐ Appointment reminders
☐ Text communication – Provide phone number below * _____	☐ Appointment reminder
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian	☐ May be posted in office
☐ Photo taken by staff (Example: pre/post procedure)	☐ May be posted on website

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

EST: 4/2016

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Records & Radiographs Release Request

Date: _____

(Prior Dental Office Information Below)

To: _____

Main Phone: _____

Fax: _____

Email Address: _____

I authorize the release of dental records, medical records, and radiographs relevant to dental treatment, or copies of such, and request that they are transferred to:

Crabtree Valley Dental
info@crabtreevalleydental.com
fax: 919-787-7789
main: 919-783-8887
2245 North Hills Drive
Raleigh, NC 27612

Patient(s) Name(s): _____

Patient's Date of Birth: _____

Patient / Guardian Signature: _____