CHERRY HILLS
DENTAL GROUP

RODNEY LOFTON, DDS

Dear New Patient:

Thank you for choosing our office to provide you with dental care.

Allow us to introduce ourselves and tell you a little about our dental practice. Cherry Hills Dental Group has been serving the West County community since 1990. Dr. Ron Schoolman, Dr. Rodney Lofton and our wonderful staff pride ourselves on providing the most **up-to-date**- dentistry available in an environment that is relaxed and comfortable. Our goal is to **prevent** problems **before** they occur and help you **maintain** healthy teeth and gums throughout your lifetime. When you come to our office for the first time, we will listen to your concerns about your dental health and needs. Your exam will include an initial oral examination and an oral cancer screening with the necessary radiographs to evaluate your teeth and gums. If more time, radiographs, or tests are needed to discuss your concerns and questions, another appointment will be scheduled.

We ask that you please **read** and **complete both sides** of the health history as well as **read** and **sign** the financial policy forms and **bring them with you on the day of your scheduled appointment.**

Again, we thank you for choosing our office for your dental needs, and we hope you will be pleased enough to recommend us to your family and friends.

Sincerely yours,

Rodney Lofton, D.D.S.

16976 Manchester Rd. P.O. Box 390 Wildwood, MO 63040
Office 636-458-9090 Fax 636-458-9536

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www.cherryhillsdental.com

Welcome! We are pleased that you have chosen Cherry Hills Dental Group to meet your dental needs. The philosophy of our practice is to provide you with high quality, long lasting, health services at moderate fee levels. To avoid misunderstandings about our financial policies, we wish to provide you with the following information:

INSURANCE PATIENTS: Our office is happy to cooperate with our patients who have dental insurance. We ask that you read your policy and be fully aware that insurance is meant to be an aid, not a pay all. Rarely is coverage 100% for **all** services.

We accept assignment of the insurance payments with the understanding that the patient must pay their **estimated copay** at the time of each appointment. In the event the insurance takes longer than 45 days to pay us, the patient will be required to pay that portion in full, or service charges will accrue at the rate of 2% per month (24% per year).

We file 99% of our insurance forms electronically. We are ONLY IN NETWORK with DELTA DENTAL. Ask for details about Insurance Premier Plan.

FINANCIAL OPTIONS

1) Bookkeeping Discount: By paying your **total treatment plan fee** with cash or check at the time of, or prior to the appointment, you will receive a 5% discount.

2) Visa, Mastercard, Discover, or American Express: Because of the charge by the bank, we cannot offer you our bookkeeping discount with credit cards.

3) Payment by Appointment: Your dental services are paid for as they are provided at each appointment. Insurance patients will pay their estimated copay amount.

4) CareCredit: We are pleased to provide this payment method which is handled similar to a credit card with monthly payments that are interest free. Ask our Office Manager for details.

I/WE HAVE READ THE ABOVE FINANCIAL POLICY AND HAVE SELECTED OPTION # _____ FOR PAYMENT OF OUR ACCOUNT.

SIGNATURE _____ **DATE**_____

TIME 09:19 AM DATE 5/7/2015

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

~~Medicaid ID:~~ Grp #

Employer ID: Pref. Dentist:

Carrier ID: Pref. Pharmacy:

Pref. Hyg:

Section 3

Referral Source:

Parent's Names:

Emerg Name/Phone:

Emerg Relationship:

Previous Dentist:

Employer:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct: **Phone #:**

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct: **Phone #:**

Time 9:18 AM

Cherry Hils Dental Group Inc

Date 5/7/2015

Medical History - 05/01/2015

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Erythromycin
☐ Jewelry/Metals ☐ Latex ☐ Sulfa Drugs ☐ Dental Anesthetics
☐ Tetracycline

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Angina	○ Yes ○ No
Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No	Artificial Joint	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Blood Transfusion	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No	Cancer	○ Yes ○ No
Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Chemotherapy	○ Yes ○ No
Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No	Chest Pains	○ Yes ○ No
Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No	Convulsions	○ Yes ○ No
Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No		

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

HIPPA

I have received notice of this office's Notice of Privacy Practices dated May 1, 2015 X

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

X Date:_____