# W. Blake Bybee, DDS

***Welcome to our practice! At Hidden Springs Dental we are committed to providing the highest standard of care while treating your dental needs. We strive to understand your needs, tailor treatment specifically to each individual patient, and to exceed expectations.***

**Today's Date _____**

## PATIENT INFORMATION

Patient Name _____Preferred Name _____DOB _____
Address _____ City _____ State _____Zip _____
Male _____ Female _____ SSN _____ Married ___ Single ___ Divorced ___ Child____
Cell/Home phone _____Work_____Preferred#_____
Email for appt. Reminder _____Driver's License#_____
Referred By _____
Phone Book Insurance Company Internet Flyer Other

## FINANCIALLY RESPONSIBLE PARTY

(If different from patient)

Name _____Married ____ Single ____Divorced _____
Mailing Address _____
Cell/home _____ Work _____Preferred# _____
DOB _____Relationship to Patient _____ Employer_____
SSN _____ Driver's License # _____
Email Address _____

Spouse/Other _____
Mailing Address _____
Cell /home_____ _____Work _____preferred#_____
DOB _____Relationship to Patient _____ Employer_____
SSN _____ Driver's License #_____
Email Address _____

## EMERGENCY/ALTERNATE CONTACT INFORMATION

Name of the nearest relative not living with you _____Relationship_____
Address _____Phone _____

# DENTAL INSURANCE INFORMATION

***Please have your insurance card(s) and photo ID ready for us to make a copy to keep on file***

Dental Insurance Company _____Phone _____

Insurance Address _____

Group #_____Subscriber Name _____ Subscriber DOB_____

Subscriber ID #/SSC _____

Employer _____ Employer Address_____

Employer Phone_____ Is this a Medicare Plan ____YES _____NO

Are you Retired _____YES _____NO Is this an individual plan ____YES ____NO

2nd Insurance Company _____Phone _____

Insurance Address _____

Group #_____Subscriber Name _____ Subscriber DOB_____

Subscriber ID #/SSC _____

Employer _____ Employer Address_____

Employer Phone_____ Is this a Medicare Plan ____YES _____NO

Are you Retired _____YES _____NO Is this an individual plan ____YES ____NO

Payment of fees not covered by your insurance plan is due at the time services are rendered. We cannot guarantee payment by your insurance company, and do not have leverage to obtain payment from your insurance company. Dental insurance policies vary widely; therefore you are required to become familiar with your policy exclusions, limitations, deductibles, and required co-payments and/or co-insurance. Dental insurance policies restrict payment for some services, use restricted fee schedules, and excludes some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment. It is your responsibility to keep our office informed of any changes in your insurance coverage, address, or employment, and failing to do so may delay payments made by your insurance company. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance is considered due and collectible from the patient.

***I authorize Dr. W. Blake Bybee and/or all associates to release to my insurance company information acquired in the course of my dental care. I authorize benefits to be paid directly to Hidden Springs Dental.***

_____ _____

*Signature of insured/subscriber, or legal guardian* *Date*

# CONSENT TO PROCEED

*• I certify these answers are accurate and correct to my knowledge. Since the change of medical conditions/medications can affect dental treatment, I understand the importance of and agree to notify Dr. Blake Bybee and/or any associate/employee of any changes at any subsequent reservation/appointment.*

*• I authorize Dr. Blake Bybee and/or any associate/employee as he/she may designate, to perform necessary procedures to maintain my dental health or the dental health of a minor or other individual(s) I am responsible for. These procedures include, but are not limited to, arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.*

*• I understand that the administration of local anesthetic may cause an untoward reaction or side effect(s), which may include but are not limited to: Bruising, hematoma, cardiac stimulation, temporary or permanent numbness and muscle soreness. I understand that on rare occasion(s) needles break and surgical retrieval may be required.*

*• I understand that as part of dental treatment, including preventive procedures such as hygiene cleanings and basic dentistry including restorations of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissue mat also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek(s) or other oral tissue to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.*

*• I understand that as part of dental treatment items including, but not limited to, crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. The unusual situations may require a series of x-rays to be taken by the physician or hospital and may in rare cases, require bronchoscopy or other procedures to ensure safe removal.*

*•I do voluntarily assume all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hope of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child(ren). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.*

| _____ | _____ | _____ |
|---|---|---|
| ***Patient Name/Legal Guardian (Print)*** | ***Signature of Patient/Legal Guardian*** | ***Date*** |
| _____ | _____ | _____ |
| ***Witness Name (Please print)*** | ***Signature of Witness*** | ***Date*** |