TARA T. SCHAACK, DDS **Clay Yeoman** **JON K. SCHAACK, DDS**

6005. Mount Rushmore Road
Rapid City, SD 57701
(605) 716-5444
Fax: (605) 341-0144

FACTS YOU SHOULD KNOW ABOUT DENTAL INSURANCE

Dental insurance is rapidly playing a larger role in helping people obtain dental treatment. We appreciate this fact. In an effort to help maximize your insurance benefits, we would like to share some facts about dental insurance with you:

Fact #1: Dental insurance is NOT meant to cover all fees; it is meant to be an aid to your investment in your dental health.

Fact #2: Many insurance companies announce that they reimburse the insured person "up to 100% of total fees". In actuality, we have found many plans cover 50% to 60% of the average fee. Some plans pay more, and some pay less. The amount your plan pays is determined by how much your employer paid for the plan. The less paid for insurance, the less you will be reimbursed.

Fact #3: Some insurance companies tell their customers that their dentist's fees are above the usual and customary fees, rather than saying "our benefits are low". Remember, you only receive what your employer puts into the plan, less the profits of the insurance company.

Fact #4: Some dental services are not covered by dental insurance. For example, some dental plans will substitute an amalgam (silver) filling fee for a posterior resin (white) filling fee. By doing this substitution, the insurance company pays a percentage on a lower fee, creating a high co-pay for you. Again, this depends on your specific insurance plans. We recommend you contact your carrier to understand your benefits completely.

Fact #5: ALL patients are charged the same fee, whether or not they have insurance coverage.

Fact #6: We can only **estimate** the amount your insurance will pay.

We will make every effort to assure your receive maximum benefits allowed under your insurance plan. We cannot, however, change dates dental care was delivered. We will complete and file your insurance forms at no charge as a courtesy to you.

Please do not hesitate to ask questions about our office procedures. We want you to be comfortable in dealing with these matters, and we urge you to consult us if you have any questions regarding our services and/or fees.

If you have any questions regarding your insurance, we will make every effort to help you understand your coverage. Please understand that we deal with hundreds of insurance plans and do not know the exact detail of every plan. If you have further questions, we ask that you contact your employer, and your insurance company. We have no influence regarding how much of the fee will be covered by insurance.

Patient Information
Confidential

Name _____ **Birthdate** _____
First Middle Initial Last

Address _____ **City** _____ **State** _____

Zip Code _____ **Phone #** _____ **Cell #** _____

Email_____ **SS#** _____ **Married** _____
(Needed to file insurance)

Employer _____ **Work #** _____

Name of person responsible for account _____ **Relationship** _____
(patient, parent of minor, guardian, spouse)

Address _____ **City** _____ **State** _____

Birthdate _____ **SS #** _____

Phone # _____ **Work #** _____

Person to contact in case of emergency _____ **Phone #** _____

How did you find out about our office? _____

_____ **The doctors at Schaack Family Dentistry reserve the right to inactivate any patient who has not been seen for 18 consecutive**
Initial **months or more. After this time your chart will be inactivated, and you will no longer be considered a patient of record.**

INSURANCE INFORMATION

Name of insured _____ **Relationship to patient** _____

Birthdate _____ **SS#** _____ **Date employed** _____
(Needed to file insurance)

Name of employer _____ **Group #** _____

Insurance Company _____ **Policy #** _____

Insurance Address _____ **Insurance Phone #** _____

Do you have a secondary dental insurance? Yes _____ **No** _____

The undersigned, herby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims or benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or my dependents and that I will be bound by this signature as though the undersigned has personally signed the particular claim. I understand that it is my responsibility to inform the dental office of any changes which affect the above information.

Signature _____ **Date** _____

Eaglesoft Medical History 2018 Current use

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? If so, for what?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?What medications?	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? If so, what type?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes
Have you been told to take antibiotics before dental procedures?	Yes No	If yes
Is there anything you would like to change about your teeth or smile?	Yes No	If yes
Have you ever been treated for periodontal disease?	Yes No	
When was your last dental visit? Any current dental issues?	Yes No	If yes
Have you taken any type of steroid or cortisone medications in last 2 years?	Yes No	If yes

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

If you do have an allergy, what is your reaction? Yes No If yes

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

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

Each row: Yes No

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

Comments:

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 Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPPA PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of Schaack Family Dentistry's Notice of Privacy Practices.

Name of Person that can receive information regarding treatment/scheduling, Date of Birth

---

Name of Person that can receive information regarding treatment/scheduling, Date of Birth

---

Name of Person that can receive information regarding treatment/scheduling, Date of Birth

---

Signature Date

CONFIRMATION CONTACT INFORMATION

We can email and/or text you of your upcoming appointments.

I, _____, authorize the staff and doctors at Schaack Family Dentistry to contact me and leave messages regarding treatment and appointments by this method:
***Please check your **PREFERRED** method of communication. If you do NOT want us to contact you at a certain number please do NOT put it down.

Cell Phone: □ **Text Message**: □ **Email Address:** □

_____ _____

If you wish to have us to continue to call you via home phone check here: ☐

Signed _____ **Dated** _____

Schaack Family Dentistry

PAYMENT OPTIONS

To keep the cost of dentistry down, and to continue to provide quality treatment, we now only accept payment in full (unless insurance) on the day of treatment. The doctors encourage their patients to ask about treatment costs and options at any time before, during, or after treatment.

WE ARE HAPPY TO OFFER OUR PATIENTS THE FOLLOWING PAYMENT OPTIONS:

Cash/Check

Visa, MasterCard, Discover

Payment Program offered with Care Credit upon credit check and approval prior to treatment

While we understand that sometimes unforeseen circumstances arise, multiple no-shows and late cancellations will result in either dismissal from our practice or requiring a $50 non-refundable deposit to schedule an appointment. If you fail to make the appointment, the deposit is forfeited as a no-show charge. When you do arrive at an appointment where the deposit was required, the deposit is either refunded or applied to treatment.

By signing below, I understand that if my account is not paid in a timely manner, the balance will be turned over to a collection agency. I will then be responsible for the fees charged by the collection agency and a 1.25% (15% APY) finance charge will be added to any account not paid in full within 60 days

IF YOUR ACCOUNT HAS TO BE TURNED OVER TO OUR EXTERNAL COLLECTIONS AGENCY, A FEE OF 20% OF THE TOTAL AMOUND DUE WILL BE ADDED TO THE ACCOUNT AS A COLLECTIONS FEE.

_____ _____

Signature Date

Informed Consent form for General Dental Procedures

As a patient at Schaack Family Dentistry, you have the right to accept or reject any treatment proposed by our doctors. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure as well as alternative treatments and the option of no treatment. You should never consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
As with all medical procedures, there are commonly known risks and potential complications in dentistry. We cannot guarantee the success of recommended treatment, nor can we guarantee that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur and you must be aware of them prior to moving forward with care.
Some of the more commonly known risks and complications of treatment include, but are not limited to:

1) Pain, sensitivity, bleeding, bruising, or tissue discomfort after treatment, including the area and/or tooth that was worked on, as well as the site where anesthetic was injected
2) Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste
3) Damage to adjacent teeth, restorations, or gingival tissue
4) An altered bite that requires further adjustment
5) Allergic reaction to anesthetic, medication or materials
6) Infection in need of medication, follow-up, procedures or other treatment
7) Soreness of the temporomandibular joint and associated facial musculature
8) Replacement of restoration, prosthesis, or appliance prior to the expected/optimal lifetime of said restoration/prosthesis/appliance
9) The necessity to extend or alter treatment based on changed clinical conditions or conditions not observed or diagnosed prior to the start of treatment
10) Swallowing or inhaling small objects

It is very important that you provide our doctors with accurate information before, during, and after treatment in our office. This includes all current and new medical conditions and medications, whether or not you deem it relevant to dental treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions and referral to specialist offices. If you fail to follow the doctor's recommendations or fail to keep your scheduled appointments, you increase the chances of a less than ideal outcome as well as potential cost and complication of treatment.
This form is intended to provide you with an *overview* of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks and complications or recommended treatment with our doctors and be certain all of your concerns have been addressed to your satisfaction by your doctor prior to starting treatment.

_____ _____

Patient Name Printed Date

_____ _____

Patient or Guardian Signature Staff Witness Signature