Summercrest Dental

Patient Name: _____ Date: _____

Preferred Name: _____ Date of Birth: _____ SSN: _____

Gender: _____ Married: _____

Wireless Phone: _____ Home Phone: _____

Email: _____

Address: _____

Dental Insurance Information:

Relationship to Subscriber: _____ Subscriber Name: _____

Subscriber/Member ID: _____ Group ID: _____

Subscriber Date of Birth: _____ Insurance Name: _____

Insurance Phone: _____ Employer Name: _____

Secondary Insurance Policy (if applicable)

Relationship to Subscriber: _____ Subscriber Name: _____

Subscriber/Member ID: _____ Group ID: _____

Subscriber Date of Birth: _____ Insurance Name: _____

Insurance Phone: _____ Employer Name: _____

Please present insurance card to receptionist

Medical History

Physician Name: _____ Physician Phone Number: _____

Please list any allergies (ex: medications, metals, pet dander): _____

_____

Are you taking any medications or supplements? _____ If yes, please list all medications and supplements: _____

_____

Have you been hospitalized in the last 2 years? _____ If yes, why? _____

Have you ever been seriously ill? _____ If yes, why? _____

Have you ever had cobalt or radiation treatment? _____

Have you ever taken cortisone or similar drugs? _____

Have you ever bled excessively from minor cuts, previous surgery, or following tooth extraction? _____

Have you ever been advised to take prophylactic antibiotics before dental treatment? _____

If yes, what circumstances? _____

Women: Are you pregnant? _____

Have you ever taken bisphosphonate medication, such as Zometa, Aredia, Bonefos, Fosamax, Boniva, or Actonel? _____

Have you ever tested positive for HIV? _____

Allergies:

Select all that apply

- ☐ Acetaminophen (Tylenol etc.)
- ☐ Aspirin (Excedrin, Bayer etc.)
- ☐ Codeine or other narcotics
- ☐ Dyes or artificial coloring
- ☐ Ibuprofen (Advil, Motrin, etc.)
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metals, plastics
- ☐ Penicillin
- ☐ Pine Nuts, Peanuts
- ☐ Sulfa Drugs/ Sulfites/ Sulfides

Other - please list: _____

Medical Conditions:

Select all that apply

- ☐ Artificial heart valve
- ☐ Congenital heart disease
- ☐ Heart arrhythmia
- ☐ Heart attack
- ☐ Daily aspirin/blood thinners
- ☐ Asthma
- ☐ Diabetes
- ☐ Pituitary disease
- ☐ Intestinal problems
- ☐ Liver disease
- ☐ Dialysis
- ☐ Trauma head, neck or body
- ☐ Chemotherapy/radiation
- ☐ Hemophilia/bruising easily
- ☐ Immune suppressed disorder
- ☐ Frequent headaches/migraines
- ☐ Infective endocarditis
- ☐ Heart disease
- ☐ Pacemaker
- ☐ Stent or bypass
- ☐ Tuberculosis
- ☐ Sinus trouble/surgery
- ☐ HIV/AIDS
- ☐ Excessive urination
- ☐ Ulcers/GERD
- ☐ I take antacids
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Organ transplant/donor
- ☐ Anemia, sickle cell disease
- ☐ Herpes/apthous ulcers
- ☐ Glaucoma
- ☐ Fainting, loss of consciousness
- ☐ Damaged valves
- ☐ Heart murmur
- ☐ Abnormal blood pressure
- ☐ Stroke
- ☐ Lung disease
- ☐ Hay fever
- ☐ I take insulin/medication
- ☐ Thyroid disease
- ☐ Acid reflux
- ☐ Bulimia
- ☐ Implants/artificial joints
- ☐ Cancer, tumor, or malignancy
- ☐ Blood disorder
- ☐ Hearing loss/hearing aids
- ☐ Cerebral palsy, brain injury
- ☐ Epilepsy or convulsion/seizure
- ☐ History drug/alcohol addiction
- ☐ Dementia, Alzheimer’s disease
- ☐ Hepatitis

Others - please list: _____

Dental History

Have you been to the dentist before? _____ Date of Last Visit: _____

What was done at your last visit? _____

Approximate Date of Last X-Rays: _____ Approximate Date of Last Full-Mouth X-Rays: _____

Approximate Date of Last Cleaning: _____

Is there anything about your smile you would like to improve or change? _____

If yes, please describe: _____

Teeth

Do you have any of the following?

- ☐ Bad taste in mouth
- ☐ Blisters on lips/mouth
- ☐ Broken or chipped
- ☐ Crooked teeth
- ☐ Tooth decay
- ☐ Difficulty chewing
- ☐ Discolored teeth
- ☐ Loose/missing filling
- ☐ Loose teeth
- ☐ Tooth pain
- ☐ Food trap areas
- ☐ Grinding or clenching
- ☐ Missing teeth
- ☐ Sensitive to temperature
- ☐ Sensitive when biting
- ☐ Sensitive to sweets

Facial/Jaw Pain

In regard to facial/jaw pain, do you

- ☐ Have frequent headaches
- ☐ Avoid certain foods
- ☐ Experience popping/clicking
- ☐ Have pain in temples
- ☐ Have times when your jaw locks open/closed
- ☐ Have pain in jaw

Orthodontic

Have you ever had orthodontic treatment? _____

Sleep/Airway Issues

Do you have any sleep/airway issues? _____ Do you currently have a CPAP? _____

Do you or have you ever had a night guard? _____

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our staff members for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments with the understanding that any uninsured portion that is not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Minors

Adult patients are responsible for full payment at the time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

I hereby authorize group insurance benefit payment directly to Summercrest Dental and Aleksandr Yanchuk, DMD. I understand that I am responsible for all costs of the dental treatment for the patient named below. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Summercrest Dental and Aleksandr Yanchuk. DMD to release the patient's dental and / or medical histories and other information about the patient's dental treatment to third-party payers and / or other health professionals.

For Patients Paying Out of Pocket

We accept cash, check, and credit card. Full payment is due at the time of service unless other arrangements have been made prior to treatment. Seniors will receive a 10% discount on all services. Non-seniors paying in full with a check or cash will receive a 10% discount on all services.

Signature: _____ Date: _____

Patient Name: _____

Notice of Privacy Policies

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature of Patient, Parent, or Guardian: _____ Date: _____

Summercrest Dental

Privacy Policy

Last revised: July 28, 2025

Privacy Policy

Summercrest Dental is committed to respecting your privacy. The following privacy policy explains how we use and protect personal information collected by our office. Please read this policy carefully. By providing your personal information to us, you acknowledge and accept the practices described below.

Our privacy practices may be updated from time to time. Any changes will apply only to information collected after the change and will not be applied retroactively.

Collected Information

We collect personal information such as names, phone numbers, email addresses, and other relevant details only when voluntarily provided by patients. The information you provide is used solely to fulfill your specific request or to provide dental care and related services, unless you give us permission to use it in another manner.

Terms & Conditions

By providing your phone number, you consent to receive phone calls and SMS text messages from Summercrest Dental regarding appointments, treatment information, and other office-related communications. Message and data rates may apply. You may opt out of SMS messages at any time by replying **STOP**.

Shared Information

We may share personal information with government agencies or other entities assisting in fraud prevention or investigation when permitted or required by law, or when investigating suspected or confirmed fraud.

We may also use third-party service providers to perform certain business functions, such as administrative support, communication services, or processing inquiries. Personal information may be shared with these providers only as necessary for them to perform their duties. We do not sell or share personal information with unaffiliated third parties for marketing purposes.

Aggregate Information

Occasionally, we may collect statistical or non-personal information for internal administrative or reporting purposes. This information does not identify individual patients and may be used to improve office operations or comply with government requests.

External References

This policy applies only to information collected directly by Summercrest Dental. We are not responsible for the privacy practices of outside organizations or entities that you may interact with independently.

Contact Us

We reserve the right to make changes to our privacy policy. Any changes to this privacy policy will be posted here. If you have any questions or concerns about our Privacy Policy, please contact us at:

Summercrest Dental

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