CARDINAL
FAMILY DENTAL

PATIENT INFORMATION AND INSURANCE

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can.
If you have any questions we'll be glad to help you.

PERSONAL

Name: ____

Last First MI (Preferred)

Birthdate: __________ SS #: ______________ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: ______________ Wireless Phone: ______________

Email: ____

Preferred Contact Method: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

Preferred Contact Method for Confirmations: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

Student status if dependent over 19 (for ins): ☐ Nonstudent ☐ Fulltime ☐ Parttime

How did you hear about us?

____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: ____

Address 2: ____

City: ______________ State: ______ Zip: __________

Home Phone: ______________

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child Subscriber DOB:

Subscriber Name: ______________________________ Subscriber ID #: ______________

Insurance Company: ______________________________ Phone: ______________

Employer: ______________ Group Name: ______________ Group #: __________

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: ______________________________ Subscriber ID #: ______________

Insurance Company: ______________________________ Phone: ______________

Employer: ______________ Group Name: ______________ Group #: __________

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Signature: ______________________________ Date: ______________

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Medical History

Last Name: First Name: Birthdate:
Name of Medical Doctor: ______________________ City/State: ______________
Emergency Contact ____________ Phone ________ Relationship ______________

List MEDICATIONS that you are currently taking. Mark Any Medications that you have stopped taking since your last appt.

- [ ] ______________________ - [ ] ______________________
- [ ] ______________________ - [ ] ______________________
- [ ] ______________________ - [ ] ______________________
- [ ] ______________________ - [ ] ______________________
- [ ] ______________________ - [ ] ______________________
- [ ] ______________________ - [ ] ______________________

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Narcotics
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Clindamycin	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Other

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma / Breathing Issues	☐	☐	Kidney / Liver Disease
☐	☐	Bleeding Problems	☐	☐	Frequent Headaches
☐	☐	Cancer	☐	☐	Pregnancy / Nursing
☐	☐	Diabetes	☐	☐	Psychiatric Treatment
☐	☐	Artificial Heart Valve	☐	☐	Communicable Diseases
☐	☐	Heart Issues	☐	☐	HIV/AIDS
☐	☐	High Blood Pressure	☐	☐	Drug Abuse
☐	☐	Joint Replacement	☐	☐	Alcohol Abuse
☐	☐	Seizures	☐	☐	History of Bisphosphonates
☐	☐	History of Head and Neck Radiation	☐	☐	Do you PREMEDICATE prior to dental Appts

Do you currently use tobacco? Which Type? ______________________
Previous Issues with Dental Treatment? ______________________
Are you happy with your smile? ____________ Current Dental Pain? ________
New patients only:
Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? ________
Do you have BiteWing x-rays that are less than 1 year old? ______________
Name of former dentist ______________ City/State __________
When was your last dental cleaning?

Signature: ______________________ Date: ____________

Financial Agreement

Last Name: First Name: Birthdate:

Date:

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of Estimated patient portion is due at the time of treatment. We strive to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1. Cash, Check, Visa, Mastercard, and Discover

2. Flexible payment plans upon approval with Care Credit. Approval must be received prior to treatment date.

As a courtesy to you, we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans may not correspond to individual patient needs, and as such, some routine and necessary dental services may not be covered even though you may need those services.

Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately, with the information provided to us by you and your insurance company, we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is processed.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

Returned Checks - A fee of $40 will be charged for any returned checks.

Minor Patients - The adult accompanying the minor is responsible for the payment on the account at the time of service.

By signing this form, I authorize Cardinal Family Dental to process credit card transactions initiated by me either by mail or phone.

I have read and fully understand my financial options and obligations.

Signature: ______________________________ Date: ___________

Notice of Privacy Policies

Last Name: First Name: Birthdate:

Date:

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: ______________________________ Date: __________

Authorization for Release of Information to Family Members

Many of our patients allow family members such as spouse, parents, and others to call and request medical/dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/dental or billing information released, you must sign this form.

I authorize Cardinal Family Dental to release my medical/dental and/or billing information to the following individual(s):

Name:

Name:

Name:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing at any time.

Signature: _________________________ Date: __________