Welcome to Cumberland Pointe Dental Care!

To help us better serve you, please fill out this form completely. If you have any questions or need assistance, please ask us and we will help.

Patient Information:

Name: ____ Date: __________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child Spouse's Name: ___________________

SS#: ______________________ Birth Date ___________________ Home Phone: ____________________

Address: ____ Cell Phone: ______________________

____ Email: _________________________

Contact Person (who does not live with you) Name: __________________________ Phone Number: ________________

Responsible Party: if child or another adult

Name of Person Responsible for Account: ________________________ Relationship to Patient: ______________

SS#: ______________________ Birth Date ___________________ Home Phone: ______________________

Address: ____ Cell Phone: ______________________

____ Email: _________________________

Insurance Information: please provide us with your dental insurance card so we may make a copy

Name of Primary Insured: ___________________________________ Relationship to Patient: ______________

SS#: ______________________ Insured Birth Date _____________ Home Phone: ______________________

Employer: ____ Work Phone: ______________________

Employer Address: ____

Insurance Company: ______________________Group # ___________ Policy #: __________________________

Insurance Company's Phone Number: ____________________________ Do you have secondary Insurance? _____

Have you used your Insurance this year or paid your deductible? _________

Referral Information:

How did you hear about our practice? ☐ Internet ☐ Mail ☐ Yellow Pages ☐ Drive By ☐ Insurance Company ☐ Referral

Who referred you to our dental practice? ☐ Patient ☐ Doctor/Dentist ☐ Spouse ☐ Friend ☐ Family Member

Name of person or office referring you to our practice: ____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected Health Information. Please see our HIPPA Notice of Privacy Practices. Thank you for choosing our practice to serve your dental needs now and in the future.

Please complete and sign the other side of this form >>

Patient Medical History:

Name of Physician: ___________________________________ Last Exam: _________________ Office Phone: ______________

	Yes	No
1. Are you under Medical Treatment now?	☐	☐
2. Are you taking any Medications?	☐	☐

If yes, what medication(s) are you taking? ________

____

____

3. Do you have or have you had any of the following?

- ☐ **Allergies:**
  - ☐ Latex ☐ Penicillin
  - ☐ Sulfa ☐ Codeine
  - ☐ Iodine ☐ Metals
  - ☐ Other _____________
- ☐ Aids/HIV
- ☐ Anemia/Hemophilia
- ☐ Arthritis
- ☐ **Artificial Joints/Parts**
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer/Tumor
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ **Excessive Bleeding**
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ Heart Attack
- ☐ **Hepatitis**
- ☐ High Blood Pressure
- ☐ Joint Replacements
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Nervous Disorders
- ☐ **Nursing**
- ☐ **Mitral Valve Prolapse**
- ☐ Pacemaker
- ☐ **Pregnancy**
  - ☐ Due Date ________
- ☐ **Pre-Medication**
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ **Rheumatic Fever**
- ☐ Sinus Problems
- ☐ Skin Rash/Hives
- ☐ Spina Bifida
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ and/or Jaw Pain
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other___________________

	Yes	No
4. Do you smoke or use tobacco products?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Have you been Hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain ____________________________

Patient Dental History:

Name of Previous Dentist ____ Date of Last Exam or Cleaning __________________

1. Have you ever had any complications during/following dental treatment? ☐ Yes ☐ No
2. Are your teeth sensitive to hot, cold or sweet liquids/foods? ☐ Yes ☐ No
3. Do you have pain in your teeth or a certain tooth? ☐ Yes ☐ No
4. Have you ever had clicking or pain in your jaws or difficulty opening or closing? ☐ Yes ☐ No
5. Do you have frequent headaches? ☐ Yes ☐ No
6. Do you clench or grind your teeth? ☐ Yes ☐ No
7. Have you ever had a difficult extraction(s) or prolonged bleeding following an extraction in the past? ☐ Yes ☐ No
8. Have you had any orthodontic treatment (braces)? ☐ Yes ☐ No
9. Do you like your smile? ☐ Yes ☐ No
10. If you could change one thing about your smile or teeth, what would it be? ___________________________________

Authorization and Release:

I certify that I have read, answered and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I also authorize the dentist(s) and/or dental office to release any information to third party payors and/or other healthcare practitioners.

X____

Practice Information and Policies

1. **Patient Information:** A fully completed, current patient information registration will be on file in your chart and in our computer during all times the patient is considered active in our practice. Patients are required to inform this office of any changes in their Medical or Dental Health since their last visit and to keep us up-to-date on an annual basis.

2. **Treatment Cost** - Nobody likes to be surprised when it comes to costs. Our policy is to inform you of what your investment will be prior to any treatment. We will review with you our recommended treatment plan and its cost. To make getting a beautiful new smile as easy as possible, we offer several convenient payment methods. Our staff is available to discuss financial arrangements and help you select the method of payment that best meets your needs.

3. **Insurance Benefits:** Please note that your dental insurance policy is a contract between you and your insurance company. We will be happy to assist you in completing and submitting copies of your insurance paperwork to your provider. At your first visit, please bring your insurance card so we may enter the appropriate information into your computerized patient file. We request that you also keep us updated as to any changes in your insurance coverage. Our staff members will be happy to assist you with any questions you may have about insurance, but the ultimate financial responsibility for dental services will be that of the patient, not the insurance company.

4. **Secondary Insurance:** We will accept Secondary dental insurance, but secondary insurance is often difficult to work with. As a courtesy, we will file secondary dental insurance for patients upon submission of proof of secondary insurance**.** However, if payment is not received in our office within 60 days of the service, the responsibility will be transferred to the patient, and the total outstanding balance will be due from the patient at that time.

5. **Patient Financial Responsibility:** It is the sole responsibility of the patient to insure that our practice accepts their insurance or is in their network. If we are not a provider, then payment in full will be expected at the time of service. All dental insurance co-payments, deductibles, non covered services and amounts above usual and customary as determined by your insurance company are due at the time of service.

6. **Finance Charges:** Any amount your insurance does not cover (deductibles, co-payments, or amounts above usual and customary as determined by your insurance company) will be due at the time of your service. We offer several convenient payment methods, but do not send monthly statements or accept monthly in-office payment plans. There will be a 1.5% finance charge per month on any balance due over 30 days.

7. **Methods of Payment:** Acceptable methods of payment are cash, check, MasterCard or Visa. Additionally, we offer several no interest payment and financing plans through outside financing companies like CareCredit.

8. **On-time Appointments:** We work hard to keep on-schedule and our patients rarely have to wait for their appointment or to see the doctor. We understand that our patients have busy lives and dental appointments are just a small part, but in order to help us keep our schedule it is very important for you to be on time for your appointment.

9. **Missed Appointment:** We understand that emergencies do arise, but if you must cancel your dental appointment we need at least 24 hours notice. Appointments missed and not previously cancelled will be charged a $25 "no show" fee for routine visits. After two "no show" appointments you may be dismissed from the practice.

10. **Dental Emergencies:** If you have a dental emergency during non-business hours you may leave a message on the answering machine. There will be an emergency number on our answering machine that you may call to reach one of the doctors. Please understand that you may need to leave a message on the doctor's private number with your name and phone number.

11. **Estimates of Charges:** If you are recommended to return for dental treatment we will provide you with a treatment plan and an estimate of what your insurance may or may not cover. Due to the nature of dental care and unforeseen problems that arise during treatment, this is only an estimate and the treatment and fees may change. In the event that your insurance pay less than the amount estimated, you are responsible for the unpaid balance.

12. **Delinquent Accounts:** Accounts that become past due over 90 days are considered delinquent and will be automatically turned over to a collection agency or our attorney. This may result in court action, adverse credit rating reporting and additional penalties and fees. In the event an account becomes delinquent, the undersigned understands that future treatment may be delayed and that the patient or responsible party will be responsible for attorney fees, collection agency fees, cost of collections, court cost and/or other expenses and fees necessary to collect the unpaid balance.

13. **Contacting Patients and Release of Information:** The undersigned grants Family Dental P.C. , Cumberland Pointe Dental Care P.C. , its doctors, staff and its assignees the right to telephone them or their contact person at home or work to discuss any matters related to this form. In order to submit claims to your dental insurance or other healthcare providers, we must have your authorization to release these medical/dental records and information. Your signature below authorizes the release of this information.

14. **Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191:** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights. This information, in detail, is available at the front desk and is posted in our waiting room. Please take time to read and understand your rights under HIPAA. If you would like an additional copy of our HIPAA form please ask us and we will make one available to you.

I have read and understand the above information and practice polices for Family Dental P.C. and Cumberland Pointe Dental Care P.C.

Print Name: ______________________________ Patient Signature: ________________________________ Date: _________