Welcome To Cities Dental Group!

PATIENT INFORMATION

NAME____ DATE__________________________________
first mi last

ADDRESS____________________________________CITY/STATE/ZIP________________________________

HOME PHONE_______________________________ CELL PHONE___________________________________

EMAIL___________________________________ *may we contact you via email?* ☐Yes ☐No

SSN____________________________________DATE OF BIRTH_________________________________

MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐ DIVORCED ☐WIDOWED ☐SEPARATED

IF COLLEGE STUDENT: FT/PT NAME OF SCHOOL________________________________

EMPLOYER____

WORK PHONE_______________________________ *may we contact you at work?* ☐Yes ☐No

SPOUSE / PARENT (GUARDIAN) NAME____

WHOM MAY WE THANK FOR REFERRING YOU?_____________________________________

EMERGENCY CONTACT____________________________________ PHONE____________________

RESPONSIBLE PARTY *(if different from above)*

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____________________________________
RELATIONSHIP TO PATIENT______________________________________

ADDRESS____ HOME PHONE___________________________

DATE OF BIRTH______________________________________ SSN______________________________________

EMPLOYER____WORK PHONE___________________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐YES ☐NO

INSURANCE INFORMATION *(if different from above)*

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT _______________

DATE OF BIRTH ___________________________ SSN ____

EMPLOYER_______________________________________ WORK PHONE______________________________

EMPLOYER ADDRESS____

INSURANCE CO.____________________ PHONE___________ GROUP #___________POLICY #__________

ADDRESS____

DO YOU HAVE A SECONDARY INSURANCE? ☐Yes ☐No
(if yes, please obtain an additional form and complete this portion)

Cities Dental Group, P.L.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____________________

Address: ____________________

Telephone: ____________________ E-mail: ____________________

Patient #: ____________________ Social Security #: ____________________

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Cities Dental Group, P.L.C. (Dr. Leandro M. Lira)**

Telephone: **763-694-7500** Fax: **763-694-7557**

E-mail: **info@citiesdentalgroup.com**

Address: **3505 Vicksburg Lane North, Suite 1200, Plymouth, MN 55447**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ____________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________

Relationship to Patient: ____________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Cities Dental Group

MEDICAL HISTORY

Patient Name: ____ Date: ________________

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, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? ☐Yes ☐No ☐N/A ____________________

Have you ever been hospitalized or had a major operation? ☐Yes ☐No ☐N/A ____________________

Have you ever had a serious head or neck injury? ☐Yes ☐No ☐N/A ____________________

Are you taking any medications, pills, or drugs? ☐Yes ☐No ☐N/A ____________________

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No ☐N/A ____________________

Are you on a special diet? ☐Yes ☐No ☐N/A ____________________

Do you use tobacco? ☐Yes ☐No ☐N/A Do you use controlled substances? ☐Yes ☐No ☐N/A

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 ☐Local Anesthetics

☐Other ____

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

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

Have you ever had any serious illness not listed above? ☐Yes ☐No ☐N/A ________________

Comments: ____

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*Condition may require medication N/A - Not Answered by Patient

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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 Date

Cities Dental Group

DENTAL HISTORY

Patient Name: ____ Birth Date: ___________________

What is your reason for this visit? ____

Date of last dental visit? ______________________ What was done then? _____________________

How often did you visit the dentist before then? ____

Previous Dentist (Name and Location)____

Have you had a complete series of dental films (X-Rays) taken? ☐Yes ☐No
If so, When? / Where? ____

How often do you brush your teeth? ___________ How often do you floss your teeth? _____________

Is your drinking water fluoridated? ☐Yes ☐No ☐Not Sure

Do your gums bleed while brushing or flossing?	☐YES	☐NO
Are your teeth sensitive to hot or cold liquids or foods?	☐**YES**	☐**NO**
Are your teeth sensitive to sweet or sour liquids or foods?	☐YES	☐NO
Do you feel pain to any of your teeth?	☐**YES**	☐**NO**
Do you have any sores or lumps in or near your mouth?	☐YES	☐NO
Have you had any head, neck or jaw injuries?	☐**YES**	☐**NO**
Do you have frequent headaches?	☐YES	☐NO
Do you clench or grind your teeth?	☐**YES**	☐**NO**
Do you bite your lips or cheeks frequently?	☐YES	☐NO
Have you noticed any loosening of your teeth?	☐**YES**	☐**NO**
Does food tend to become caught between your teeth?	☐YES	☐NO
Have you ever had periodontal treatment (gums)?	☐**YES**	☐**NO**
Ever wore a bite plate or other appliance?	☐YES	☐NO
Have you ever had any difficult extractions in the past?	☐**YES**	☐**NO**
Have you ever had prolonged bleeding following extractions?	☐YES	☐NO
Do you use a soft bristled toothbrush?	☐**YES**	☐**NO**
Do you wear dentures or partials?	☐YES	☐NO

If Yes, date of placement:_______________________

Have you ever experienced any of the following problems in your jaw?

Clicking	☐YES	☐NO
Pain	☐YES	☐NO
Difficulty opening or closing	☐YES	☐NO
Difficulty chewing	☐YES	☐NO

____ ___________________
Signature of Patient, Parent or Guardian Date

____ ___________________
Signature of Doctor Date

Cities Dental Group
Financial Policy

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

All patients must complete our patient registration, medical history and insurance forms before seeing the doctor,

PAYMENT IS DUE AT THE TIME OF THE SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, OR DISCOVER. A FINANCE CHARGE OF 1.5% WILL BE CHARGE FOR ANY UNPAID BALANCES PAST 30 DAYS AND A FINANCE CHARGE OF 22.9% PER MONTH WILL BE CHARGED FOR ANY BALANCE PAST 60 DAYS. **PLEASE INFORM STAFF BEFORE TREATMENT IS STARTED IF PAYMENT CANNOT BE MADE**. IF IN DEFAULT OF THIS AGREEMENT, PATIENT WILL BE RESPONSIBLE FOR COLLECTION AGENCY FEES AS WELL AS ANY COURT COSTS AND LEGAL FEES NECESSARY TO COLLECT THE DEBT.

Regarding Insurance
We accept payment of insurance benefits upon completion of your treatment. However, we do require your estimated portion of the bill to be paid at the time of service. We cannot bill your insurance company unless your give us your insurance information. Your insurance policy is a contract between you and your insurance company: we are not a party to that contract. If your insurance company has not paid your account in full within 90 days of being billed, the balance will be your responsibility.

Patients under 18
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless chares have been pre-authorized to an approved credit plan.

Missed Appointments
Unless cancelled at least 24 hours in advance, our policy is to charge $55.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy and I understand and agree to this Financial Policy.

X____ Date ________________

Signature of Patient or Responsible Party