# Welcome to
# Cedar Hills Dental

## About You

Today's Date: _____ E-mail Address: _____

**Name:** _____ Mr. Mrs. Ms. Dr. (please circle one)
Last First Mi

Birthdate: _____ Age: ___ Social Security #: _____ Male ☐ Female ☐

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated I prefer to be called: _____

**Home Address:** _____
Street City State Zip

Home # (___)_____ Cell # (___)_____ Work # (___)_____ ext.____ Drivers License #:_____

Best times to reach you? _____ Whom may we thank for referring you?_____

Other family members seen by us: _____

**Employer:** _____ How long? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

## Medical History

Do you have a personal physician? ☐ yes ☐ no

Physician's name: _____

Address: _____
Street City State Zip

Phone # (____)_____ Date of last visit: _____

**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ yes ☐ no

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ yes ☐ no

**Are you allergic to any of the following?**

| | | |
|---|---|---|
| Y N Aspirin | Y N Erythromycin | Y N Sedatives |
| Y N Barbiturates | Y N Jewelry/Metals | Y N Sulfa Drugs |
| Y N Codeine | Y N Latex | Y N Tetracycline |
| Y N Dental | Y N Penicillin | Y N Other |

Anesthetics

Please list additional drugs/materials that cause allergic reactions: _____

_____

**Are you taking any of the following?**

| | | | |
|---|---|---|---|
| Y N Acetaminophen | Y N Blood Thinners | Y N Insulin/Diabetes Drugs | Y N Thyroid Medicine |
| Y N Antibiotics | Y N Blood Pressure Medication | Y N Nitroglycerin | Y N Tranquilizers |
| Y N Antihistamines | Y N Cold Remedies | Y N Recreational Drugs | Y N Birth Control Pills |
| Y N Aspirin | Y N Digitalis/Heart medication | Y N Steroids/Cortisone | Y N Cholesterol Meds |

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ☐ yes ☐ no

If yes, please list each one: _____

_____

**Do you or have you experienced the following?**

| | | | | |
|---|---|---|---|---|
| Y N Abnormal Bleeding | Y N Headaches | Y N Kidney Problems | Y N Seizures | Y N Tuberculosis (TB) |
| Y N Congenital Heart Defect | Y N Heart Attack | Y N Liver Disease | Y N Shingles | Y N Ulcers |
| Y N Anemia | Y N Diabetes | Y N Heart Murmur | Y N Low Blood Pressure | Y N Sickle Cell Disease |
| Y N Arthritis | Y N Difficulty Breathing | Y N Heart Surgery | Y N Lupus | Y N Sinus problems |
| Y N Artificial Bones/Joints | Y N Drug/Alcohol Abuse | Y N Hemophilia | Y N Mitral Valve Prolapse | Y N Steroid Therapy |
| Y N Artificial Valves | Y N Emphysema | Y N Hepatitis | Y N Pacemaker | Y N Stroke |
| Y N Asthma | Y N Epilepsy | Y N Herpes | Y N Thyroid Problems | Y N Hay Fever |
| Y N Blood Transfusion | Y N Fainting Spells | Y N High Blood Pressure | Y N Psychiatric Problems | Y N Hospitalized for |
| Y N Cancer | Y N Fever Blisters | Y N HIV+/AIDS | Y N Radiation Treatment | _____ |
| Y N Chemotherapy | Y N Glaucoma | Y N Rheumatic Fever | Y N Scarlet Fever | _____ |

**Females: Are you or could you be pregnant? ☐ yes ☐ no**

Please list any serious medical condition(s) that you have experienced: _____

_____

_____

_____

_____

# Insurance Information

**Insurance Co. Name:** _____ **Group #:** _____
**Insurance Co. Address:** _____
Street/PO Box City State Zip
**Insurance Co. Phone #:** (___)_____ **Insured's Social Security #:** _____
**Insured's Name:** _____ **Relation:** _____ **Birthdate:** _____
**Insured's Employer:** _____ **Insured's Work #** (____)_____
**Employer's Address:** _____
Street City State Zip

**Spouse Information or Person Responsible for Account if other than yourself**

Name: _____ Home # (____)_____ Work #: (____)_____ ext. ____
Employer : _____ Relationship: _____
Social Security #: _____ Birthdate: _____ Drivers License #: _____
Billing Address: _____
Street City State Zip

# Dental History

Why have you come to the dentist today?_____
_____

Are you currently in pain? ☐ yes ☐ no
Do you require antibiotics before dental treatment? ☐ yes ☐ no
Have you experienced problems associated with any previous dental work? ☐ yes ☐ no
Do you now of have you ever experienced pain/discomfort In your jaw joint (TMJ/TMD)? ☐ yes ☐ no
Your current dental health is ☐ Good ☐ Fair ☐ Poor
Do you floss daily? ☐ yes ☐ no Brush daily? ☐ yes ☐ no
Type of bristles on your toothbrush? ☐Hard ☐ Medium ☐Soft
Do you use anything in addition to your brush and floss? ____
If yes, what?_____
Would you like fresher breath? ☐ yes ☐ no
Whiter teeth? ☐ yes ☐ no

Do your gums ever bleed? ☐ yes ☐ no
Have you ever had periodontal disease? ☐ yes ☐ no
Do you have mobility in your teeth? ☐ yes ☐ no
Are your teeth sensitive to heat, cold, or anything else? ☐ yes ☐ no
Do you wear any removable appliances? ☐ yes ☐ no

Previous/Present Dentist: _____
(Circle one) Date of last visit: _____
Why did you leave your previous dentist?_____
_____

**Are you happy with the way your smile looks?** ☐ yes ☐ no
If not, what would you change? _____
_____

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any changes in my health history or change in my medication, I will inform the office staff or dentist at the next appointment.

I consent to the performing of dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated.

_____
Signature Date

_____
Doctor's Signature

CEDAR HILLS DENTAL

Thank you for choosing us as your dental care provider. The following is a statement of our financial policy which we require you to read and sign prior to receiving treatment. If you have any questions during your exam today, please feel free to ask.

## CANCELLATION POLICY

If you are unable to keep an appointment, kindly give our office 24 hour notice to avoid a failed appointment charge of $25.00 per ½ hour of appointed time. We will make every attempt to contact you to verify your appointment. Occasionally, we are only able to leave a message or are unable to contact you. We ask that you please be responsible for keeping your appointment.

## FINANCIAL POLICY

**Private Pay Patients:** Full payment is due at the time of service. We accept cash, checks, MasterCard, and VISA. In some instances, we will also accept post-dated checks. If you are interested in a monthly payment plan, a healthcare finance plan is available. Please see the receptionist for complete details.

**Insurance Plans:** We are happy to accept insurance assignments, but we wish patients to be aware that this service in no way relieves you from the responsibility of your bill. In order for us to file your insurance, we must have a copy of your current insurance card.

If you have an insurance plan that we are providers for, payment for all co-pays and deductibles are due at the time services are rendered.

If you have an insurance plan that we are not providers for, full payment is due at the time of service. We will gladly give you a claim form at the end of your appointment so that you may file the claim with your insurance company for reimbursement.

**Please Note: It is your responsibility to know your insurance policy rules and benefits.**
Our office files claims to many different insurance companies, and it is virtually impossible to know every detail of your individual insurance policy. Please be aware that some of the services provided may be considered by your insurance company to be a non-covered service or may be covered at a reduced benefit level. You have the right to refuse any services rendered to you if you think they are non-covered services or not payable by your insurance company.

Our goal is to provide our patients with the best dental care available; therefore, we do not allow insurance companies to dictate the best treatment for our patients. We will not become involved in disputes between you and your insurance company regarding non-covered or reduced-benefit services. Please refrain from asking our office to change a diagnosis or procedure code in order for services to be covered by your insurance company.

## ASSIGNMENT OF BENEFITS AGREEMENT

I understand that I am fully responsible for my account after insurance benefits have been received. If my insurance benefits are denied, I will pay my account in full within 30 days. I understand that assignment of benefits is a courtesy extended to me, and I will give my full cooperation until my account is paid in full.

_____ _____

Patient/Responsible Party Signature Date

Patient Full Name: _____ Date of Birth: _____
(Please Print)

## Privacy Practices Acknowledgement and Receipt

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, this information must be completed and updated annually by the patient or guardian.

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give the Physician Associates group and its providers and employees my permission to discuss freely my condition, treatment or diagnosis with that person present.

**(Circle one) YES NO**

### Notice of Privacy Practice:

By signing below, I acknowledge that I have been provided a copy of this facility's Notice of Privacy Practices Form 3732-3732-PPSI-2061 (Rev. 02/10) for review and a personal copy to keep will be provided upon request.

**Signature of Patient or Guardian:** _____ **Date:** _____

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## Release of Personal Health Information (PHI)

This information must be completed and updated every 6 months by the patient or guardian.

This release authorizes the Physician Associates group to discuss medical information regarding my care, condition, treatment or diagnosis with the following:

☐ **Patient Only**

☐ **Spouse (*Specify Name of Spouse):*** _____

☐ **Parent (*Specify Name of Parent(s)*):** _____

☐ **Other *(Please specify)*:** _____

**When contacting you with test results such as labs, x-rays, etc., please mark one or all desired:**

☐ Home Phone: _____ May we leave a detailed message: **YES / NO**

☐ Work Phone: _____ May we leave a detailed message: **YES / NO**

☐ Cell Phone: _____ May we leave a detailed message: **YES / NO**

**Signature of Patient or Guardian:** _____ **Date:** _____

**Relationship to Patient:** _____ (i.e., Self, Parent)