Cedar Mountain Family Dentistry

Date:_____

Patient Information

Last Name:_____ First Name: _____ Middle Initial: _____

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address:_____ Do you want reminders? ❑ Yes ❑ No

Social Security Number: _____

Occupation:_____ Employer:_____ Employer Phone:_____

How did you hear about us? *Insurance, Friend/Family, Google, Internet, Other*: _____

In Case of Emergency Contact

Name:_____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Account Information

Insurance Company: _____ ID Number:_____ Group Number:_____

❑ Person responsible for this account is the same as above

Last Name:_____ First Name: _____ Middle Initial: _____

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address:_____

Social Security Number: _____

Occupation:_____ Employer:_____ Employer Phone:_____

Agreement & Consent

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment,including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or responsible Party Signature: X_____ Date: _____

Patient Name: _____ Today's Date: _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of last exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Do you use any form of tobacco?	☐	☐
4. Do you have a persistent cough?	☐	☐

6. Women Only	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills	☐	☐

Approx. date of last dental appointment? _____

Please list any allergies (esp. Penicillin, Anesthetics, Aspirin): _____
_____.

Please list any current medications _____
_____
_____.

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Sleep Apnea	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Tuberculosis	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Allergies	☐	☐
Fainting / Seizures	☐	☐	Angina / Chest Pain	☐	☐	Stroke	☐	☐
Asthma	☐	☐	High Cholesterol	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐
Epilepsy	☐	☐	Respiratory Problems	☐	☐	Heart Trouble	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Joint Replacement / Implant	☐	☐	Anemia	☐	☐
Kidney Disease	☐	☐	Hepatitis / Jaundice	☐	☐	Other _____		
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	_____		
Thyroid Problems	☐	☐	Radiation Therapy	☐	☐	_____.		

PATIENT DENTAL HISTORY

	Yes	No
1. Gums bleed while brushing or flossing?	☐	☐
2. Teeth sensitive to Cold or Hot?	☐	☐
3. Teeth sensitive to Sweets?	☐	☐
4. Pain in any teeth?	☐	☐
5. Sores or lumps in or near mouth?	☐	☐
6. Any head, neck, or jaw injuries?	☐	☐
7. Any of the following jaw problems?		
a) Clicking	☐	☐
b) Pain	☐	☐
c) Difficulty opening/closing	☐	☐
d) Difficulty chewing	☐	☐

	Yes	No
8. Have frequent headaches?	☐	☐
9. Clench or grind teeth?	☐	☐
10. Suffer from bad breath?	☐	☐
11. Severe snoring (you or spouse)?	☐	☐
12. Prolonged bleeding following extractions?	☐	☐
13. Interest in Straightening Teeth?	☐	☐
14. Interested in Whitening?	☐	☐
15. Reason for visit? _____		
_____		
_____.		

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____ _____

Patient, Parent or Guardian ***Date***

Cedar Mountain Family Dentistry

Receipt of Notice of Privacy Practices-Written Acknowledgment Form

I, ___________________________, have been offered a copy of Cedar Mountain Family Dentistry's Notice of Privacy Practices for review. (Also available on our web site).

____ _________________________

Signature of Patient Date

★★

Cancellation and Payment Policies

Cancellation Policy

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time. Our office rarely runs behind - this is because we do not overbook appointments in anticipation of cancellations. We therefore strictly enforce our cancellation policy.

Our cancellation policy is as follows:

- ✯ A 24 hour notice is required.
- ✯ The first no-show or short notice cancellation will result in a $75.00 fee
- ✯ The second no-show or short notice cancellation will result in a $75.00 fee, and you will be placed on a same day only list. At that time you will be free to schedule a same day appointment with our office at anytime, but no appointment will be made in advance.

Payment Policy Contract

Patients are responsible for payment, co-payments and deductibles at time of service. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts. In the event our office is not contacted within 30 days of you receiving our last billing statement your account will be turned over to our collection agency.

In addition, I assign directly to Cedar Mountain Family Dentistry all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I also verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief. I authorize Cedar Mountain Family Dentistry to release my complete records to my insurance company in order to process my claim and for any other physicians or medical facilities that may be pertinent and necessary to care and treatment.

I____ have reviewed the above payment and cancellation policies.

____ _________________________

Signature of Patient Date