New Patient Registration

PERSONAL INFORMATION Today's Date:

Last Name: First Name:

Preferred Name: Gender: □ Male □ Female

Date of Birth: Social Security Number:

Mailing Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Email:

Appointment confirmation preference: □ Phone □ Text □ Email (check all that apply)

Employer: Occupation:

Employer Address:

City: State: Zip Code:

Family members who are currently patients at CFD:

How did you hear about us?:

Present/Past Dentist: Last Visit Date:

Emergency Contact Name:

Phone Number: Relation:

Do you have dental insurance? □ Yes □ No

If yes, please provide the office staff with a copy of your card.

MEDICAL HISTORY

Physician's Name: _____ Phone Number: _____

Your current physical health is: □ Good □ Fair □ Poor

Are you currently under the care of a physician?: □ Yes □ No

If yes, please explain: _____

Have you had any surgeries in the last five years?: □ Yes □ No Date: _____

If yes, please explain: _____

Have you ever had a joint replacement?: □ Yes □ No Date: _____

Are you taking any prescription or over-the-counter medications?: □ Yes □ No

If yes, please list: _____

Have you ever taken Fosamax, Phen-fen, or any bisphosphonate?: □ Yes □ No

Are you allergic to any of the following?:

□ Aspirin □ Chlorhexidine □ Codeine □ Dental Anesthetics

□ Erythromycin □ Iodine □ Jewelry □ Latex

□ Metals □ Penicillin □ Tetracycline

□ Other _____

FOR WOMEN ONLY:

Are you using a prescribed method of birth control: □ Yes □ No

Are you pregnant?: □ Yes □ No If yes, how many weeks?: _____

Are you nursing?: □ Yes □ No

Have you ever had any of the following diseases or medical problems?

□ Abnormal bleeding	□ Alcohol/drug abuse	□ Anemia
□ Arthritis	□ Artificial bones/joints/valves	□ Asthma
□ Blood transfusion	□ Cancer/chemotherapy	□ Colitis
□ Congenital heart defect	□ Diabetes	□ Difficulty breathing
□ Emphysema	□ Epilepsy	□ Fainting spells
□ Frequent headaches	□ Glaucoma	□ Hay fever
□ Heart attack (family history)	□ Heart murmur	□ Heart Surgery
□ Hemophilia	□ Hepatitis (what type:)	□ Herpes/fever blisters
□ High blood pressure	□ HIV+/AIDS	□ Kidney problems
□ Liver disease	□ Low blood pressure	□ Mitral valve prolapse
□ Pacemaker	□ Psychiatric problems	□ Radiation treatment
□ Rheumatic/scarlet fever	□ Seizures	□ Shingles
□ Sickle cell disease/traits	□ Sinus problems	□ Stroke (family history)
□ Thyroid problems	□ Tuberculosis (TB)	□ Ulcers
□ Venereal disease	□ Other _____	

DENTAL HISTORY

Your current dental health is: □ Good □ Fair □ Poor

Are you currently in pain?: □ Yes □ No

Have you ever had difficulty with previous dental work?: □ Yes □ No

Do your gums ever bleed? □ Yes □ No

Do you require antibiotics before dental treatment?: □ Yes □ No

How many times a day do you brush?: ☐ How many times a week do you floss?: ☐

Type of bristles: □ Soft □ Medium □ Hard

Do you smoke or use tobacco?: □ Yes □ No

The information I have provided on this form is correct to the best of my knowledge.

Signature: ☐ Date: ☐

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. 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 any treatment.

- Payment is due at the time of service.
- If you have insurance, we expect you to pay your estimated portion at the time of service.
- We accept cash, checks or credit cards.
- We offer an extended payment plan with prior credit approval.

Insurance

We are an out-of-network provider for all insurance benefits and we file your insurance claims for you as a courtesy. Your insurance policy is a contract between you and your insurance company and it is your responsibility to ensure we have correct and current insurance information. Please be aware that some of the services we provide may not be covered under your insurance policy. We do require that you pay your estimated portion and deductible at the time of service. Once your insurance company has paid your benefits, you are responsible for any remaining balance.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual
and customary rates.

Late Fees and Collection Costs

If a payment is not paid within the terms of an agreed upon payment plan, Carbondale Family Dental may asses a delinquency charge in an amount not exceeding the greater of 10% of the unpaid amount of the installment not to exceed $15.00 provided that such charge may be collected at the time it accrues or any time thereafter but only one such charge shall be made for each installment in default regardless of the length of the period it remains unpaid.
In the event of any default, Carbondale Family Dental may declare the entire unpaid balance to be immediately due and payable. If Carbondale Family Dental then assigns this agreement to a collection agency for recovery, the patient will also be responsible for up to 30% of the unpaid principle balance as the reasonable cost of collection.

Minor Patients

The adult accompanying a minor is responsible for payment.

Missed Appointments

We ask that you please call at least 24 hours in advance if you cannot keep your appointment. If you miss appointments, we ask that you provide a credit card to secure your future appointment. A fee will be assessed for repeated missed appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions regarding this policy.

I have read, understand, and agree to this Financial Policy. In the event that my account is turned over to a collection agency, I agree to pay all reasonable collection fees and court costs.

Signature: _____ Date: _____

HEALTH PRIVACY NOTICE

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

I acknowledge that I have received a copy and/or read the Carbondale Family Dental Notice of Privacy Policies.

Signature: _____ Date: _____