CARMI FAMILY DENTAL

Creating Confidence. Smile After Smile.

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(618) 382-8300 • info@carmifamilydental.com

Date_____

Patient Information

First Name_____ Middle Initial_____ Last Name_____

Date of Birth_____ Gender: F M Family Status: Married Single Other

If Minor, Parent/Guardian Name_____

Address_____ City _____State _____ Zip_____

Phone: Home_____ Cell_____
Work_____

Email_____ Referred to Our Office By_____

Emergency Contact Information

Name_____ Address_____ City _____State_____

Phone Number_____ Relationship to Patient_____

Spouse or responsible Party Information

First Name_____ Middle Initial_____ Last Name_____

Birthday_____
_____

Address if Different than Patient_____

Phone
Number_____

Relationship to
Patient_____

Insurance Information

Primary Dental Insurance

Insurance Company Name_____

Group Number_____

Subscriber Name_____

Subscriber Date of Birth_____

Subscriber ID_____

Subscriber Social Security Number_____

Place of Employment_____

Secondary Dental Insurance

Insurance Company Name_____

Group Number_____

Subscriber Name_____

Subscriber Date of Birth_____

Subscriber ID_____

Subscriber Social Security Number_____

Place of Employment_____

* **Please submit insurance card to receptionist so we can have a copy on file.**

* **While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.**

Medical History

Please Circle Y or N individually for each question:

Y N Pre-Med	Y N Diabetes	Y N Liver Disease
Y N Allergy- Penicillin	Y N Dizziness	Y N Mental Disorders
Y N Allergy – Codeine	Y N Epilepsy	Y N Nervous Disorders
Y N Allergy Erythro	Y N Excessive Bleeding	Y N Pacemaker
Y N Allergy- Other	Y N Fainting	Y N Pregnant
Y N Allergy – Aspirin	Y N Glaucoma	Y N Radiation Treatment
Y N Allergy – Latex	Y N Head Injuries	Y N respiratory Problems
Y N Allergies	Y N Heart Disease	Y N Rheumatic Fever
Y N Anemia	Y N Heart Murmur	Y N Rheumatism
Y N Arthritis	Y N Hepatitis	Y N Sinus Problems
Y N Artificial Joints	Y N High Blood Pressure	Y N Stomach Problems
Y N Asthma	Y N HIV	Y N Stroke
Y N Blood Disease	Y N Jaundice	Y N Tuberculosis
Y N Cancer	Y N Kidney Disease	Y N Tumors

Please List Current Medications

_____

_____

_____

Is there anything about your smile you would like to change?

_____

Are you interested in replacing any missing teeth?

_____

How frequently do you brush your teeth?

_____

_____

_____

Do you have any other health issues that are not listed above? If so please list.

_____

_____

Financial Policy

- On your first visit we expect you to supply our office with your insurance information. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

- While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.

- Insurance balances are ultimately the patient's obligation. We will file most insurance companies at no cost to you as a courtesy. Some of your treatment may NOT be covered by your insurance carrier. The cost for such charges will be your responsibility.

- If you do not have dental insurance, full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

- All treatment quotes are considered estimates. Ultimately it is the insurance company's decision on what is paid.

- There will be a fee of $25 for all checks returned.

- Financial options are available to all patients. (CareCredit) Please ask to speak with the financial advisor if you desire to set up a payment plan.

- Patient balances that go unpaid for 60 days or more may incur one or more of the following charges:

    - Interest charges of 2% per month
    - Small Claims Legal Fees
    - Collection Agency Fees

Patient Consent

- I authorize Carmi Family Dental to perform all recommended treatment.
- To the best of my knowledge, all of the proceeding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.
- I understand that I am responsible for the full amount of all dental fees incurred. Any payments received by Carmi Family Dental from my insurance carrier will be credited to my account or refunded to me if I have paid the dental fees incurred.
- I hereby authorize the above named dentist to release any information regarding services rendered and allow a photocopy of my signature to be used to file insurance. I herby authorize and direct my insurer to issue payment checks for benefits due me for the services rendered by the above dentist to be made directly to him.
- For patients with **Delta Dental** Insurance: I agree to submit all checks sent to me by **Delta Dental** for payment on my account with Carmi Family Dental.

HIPAA

I have received a copy of the notice of Privacy Practices of Carmi Family Dental. I hereby authorize, as indicated by my signature below, Carmi Family Dental to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the patient consent form.

Please list anyone else you would like to share this information with.

Authorization

I herby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and /or inaccurate information has the potential of being hazard to my health. I authorize the dentist to release any information to health care practitioners.

Signature: _____ Date: _____