PATIENT INFORMATION

First Name: ______________________ **Middle Initial:** _______ **Last Name:** ______________________

Preferred Name: ______________________

Gender: Female Male **Family Status:** Married Single Other

Date of Birth: ______________________ **Social Security Number:** ___________________________

Driver's License Number: _____________________ **Employer:** _____________________________

If Minor, Parent/Guardian: ____

Address: ____**City:** ______________________

State: ________ **Zip:**______________

Phone: Home: __________________**Cell Phone:** __________________**Work:** __________________

Email: ____

How did you hear about our office? ____

EMERGENCY CONTACT INFORMATION:

Name: ____**Phone Number:** _____________________

Relationship to Patient: _____________________

PATIENT CONSENT

- I authorize Carmi Family Dental to perform all recommended treatment agreed upon by myself and my doctor.
- 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 hereby authorize Carmi Family Dental to release any information regarding services rendered and allow a photocopy of my signature to be used to file insurance. I hereby authorize and direct my insurer to issue payment checks for benefits due me for the services rendered by the above dentists to be made directly to him.

Patient Signature: ____________________________________ **Date:** ________________________

MEDICAL HISTORY

Please Circle Y or N individually for each question:

Y N Pre-Med	Y N Epilepsy	Y N Radiation Treatment
Y N Allergy- Penicillin	Y N Excessive Bleeding	Y N Respiratory Problems
Y N Allergy – Codeine	Y N Fainting	Y N Rheumatic Fever
Y N Allergy - Erythro	Y N Glaucoma	Y N Rheumatism
Y N Allergy- Other	Y N Head Injuries	Y N Sinus Problems
Y N Allergy – Aspirin	Y N Heart Disease	Y N Sleep Apnea*
Y N Allergy – Latex	Y N Heart Murmur	Y N Stomach Problems
Y N Allergies	Y N Hepatitis	Y N Stroke
Y N Anemia	Y N High Blood Pressure	Y N Tuberculosis
Y N Arthritis	Y N HIV	Y N Tumors
Y N Artificial Joints	Y N Jaundice	Y N Ulcers
Y N Asthma	Y N Kidney Disease	Y N Venereal Disease
Y N Blood Disease	Y N Liver Disease	Y N Currently pregnant
Y N Cancer	Y N Mental Disorders	Y N Recently hospitalized
Y N Diabetes	Y N Nervous Disorders	Y N Tobacco use
Y N Dizziness	Y N Pacemaker	Y N *Do you use a machine for Sleep Apnea?

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**. It is the responsibility of the patient to verify that any and all dental care which they receive is in their provider network.
- Insurance balances are ultimately the patient's obligation. We will file claims to 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.**
- **All treatment quotes are considered estimates**. Ultimately it is the insurance company's decision on what is paid.
- 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.
- There will be a $25 fee for all returned checks.
- Financial options are available to all patients. (Care Credit) 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% each month
    - Small Claims Legal Fees
    - Collection Agency Fees
    - Attorney Fees
- **Some Insurance Companies send payment to the policy holder and not to our office. Patient understands that they are responsible for endorsing any check(s) received from the Insurance Company and submitting them to Carmi Family Dental for payment on their account.**

___________ **(initial)** Release to bill insurance and assign benefits

INSURANCE INFORMATION:

Insurance Company**:** ______________________________

Policy Holder Name**:** ____

Policy Holder Date of Birth: _____________ Social Security Number: _________________

Policy Holder Address: ____

Relationship to Patient: ____

Policy Holder Employer: ____

Patient Signature: ______________________________ **Date:** ________________

HIPAA ACKNOWLEDGEMENT

The undersigned acknowledges receipt of a copy of the current Privacy Policy for Carmi Family Dental. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT RECORDS OR PRESCRIPTIONS TO BE SENT TO OTHER REFERRED FACILITIES IN THE FUTURE.

_________________________________ _________________________________

(Print Name) (Signature)

PLEASE LIST ANY OTHER PARTIES WHO CAN ACCESS OR BE INFORMED OF YOUR HEALTH INFORMATION (This includes step parents, grandparents, or any other care takers who can have access to this patient's records):

Name: ________________________________ Relationship: ______________________

Name: ________________________________ Relationship: ______________________

Name: ________________________________ Relationship: ______________________

I AUTHORIZE CARMI FAMILY DENTAL TO CONFIRM MY APPOINTMENTS VIA TEXT MESSAGE and EMAIL.

YES or NO

I AUTHORIZE CARMI FAMILY DENTAL TO CALL ME REGARDING INFORMATION ABOUT MY HEALTH, CONFIRMATION OF MY APPOINTMENTS, & TREATMENT & BILLING INFORMATION TO BE CONVEYED VIA:

Cell Phone Home Phone

Work Phone Any of the Above

I AUTHORIZE CARMI FAMILY DENTAL TO **LEAVE ME A MESSAGE** REGARDING APPOINTMENTS OR MY HEALTH ON:

Cell Phone Home Phone

Work Phone Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your overall health. We, under HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Patient Signature: _______________________________ **Date:** ______________________