CARMI FAMILY DENTAL
Creating Confidence. Smile After Smile.

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:** _____

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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:** _____

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Late Cancellation and No-Show Fee

To provide exemplary service to you and other patients, it is imperative that you arrive to your scheduled appointment on time. Please be courteous and call our office as soon as possible, but no later than 24-hours prior to your scheduled appointment, if you are unable to attend. Appointments are in high demand, and early cancellation will allow another patient access to timely dental care. After a grace period of three no-show or late cancellations (less than 24-hour notice before your appointment), you will be subject to a **$50.00 non-refundable no show/late cancellation fee to reschedule the appointment.** Meaning, if you do not show up or you do not notify the office 24-hours prior to your scheduled appointment, you will be asked to provide your credit card information to reschedule an appointment or any appointment thereafter.

The only exception after the grace period of three no-show or late cancellation is if your appointment needs to be rescheduled or cancelled because of adherence to the Carmi Family Dental COVID Policy and Plan which states if a patient has COVID Symptoms, has a meaningful exposure, or has had a positive COVID test they must reschedule/cancel their appointment.

Patient Signature: _____

Date: _____