PATIENT INFORMATION

Welcome to Complete Care Dental! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient name (First/MI/Last)_____ **Preferred name** _____
Birth date_____ If minor, name of guardian_____
Home phone _____ Work phone _____ Cell phone _____
Email: _____ **Patient Social Security#:** _____
Mailing address _____ City _____State ___ Zip _____
Employer _____ Occupation _____

If married, Spouse's Name _____ Spouse's employer _____

Whom may we thank for referring you to our office?
☐ INSURANCE ☐ LOCATION ☐ INTERNET ☐ Other:_____

BILLING, CREDIT, AND INSURANCE INFORMATION: ☐ Not covered by dental insurance
Financially Responsible Party: ☐ SELF ☐ OTHER
Name of Financially Responsible: _____ **Date of Birth** _____ **SS#**_____
Mailing address _____ City _____State ___ Zip _____
Dental Insurance Co._____ Group number_____ Member ID_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please CIRCLE all that apply)

Rheumatic Fever	Asthma	Ulcers/ stomach problem	Grind Teeth/clenching
Heart Murmur	Allergies or Hives	Arthritis	Pain in Jaw (TMJ)
Heart Valve Issue	Anemia	Latex Allergy	Any type of implant
Diabetes	HIV positive/AIDS	Sinus Problems	Any type of transplant
Pacemaker/Heart surgery	Hepatitis (Type:_____)	Cancer (type:_____)	Any artificial hip, knee, or other joint
High Blood Pressure	Excessive Bleeding	Chemotherapy	Bleeding gums
Low Blood Pressure	Liver Disease	Radiation Therapy	Stroke
Have you taken Steroids or **Cortisone** in the past 2 years?	Are you taking Aspirin or **anticoagulants** such as Plavix or Coumadin?	Are you taking or EVER taken **bisphosphonates** or other **bone density drugs** , such as Fosamax, Actonel or **Prolia**?	Use of Marijuana / THC/ Cannabis Last time used**: _____
Other Heart Problem: please specify:_____	Kidney Disease/ Dialysis	Drug Addiction / Alcoholism	Use of Tobacco Products
Lung Disease	Thyroid Disease	Psychiatric Treatment	Dental Fears
Breathing Problem	Epilepsy or Seizures	Depression/ Anxiety	Easy Bruising
Tuberculosis (TB)	Fainting or dizzy spells	Mouth sores or growths	Dry Mouth

Do you have **any other disease, condition, or problem** not listed above that you feel we should know about? Please describe _____

Patient/ Guardian Signature: _____ **Date:** _____

***Use of Marijuana/Cannabis/ THC within 24-48hrs of dental treatment can cause severe heart reactions.*

Please list **all medications** you are currently taking:

_____
_____
_____

Are you allergic or have you reacted adversely to any of the following? (please circle)

Penicillin or other Antibiotics	Aspirin, Tylenol, or Ibuprofen
Sulfa Drugs	Codeine, Demerol or other narcotics
Local Anesthetics "novocaine"	Other: _____

Women Only: please circle

Is there a possibility of pregnancy? Yes No	Are you Nursing? Yes No
Estimated delivery date _____	Are you taking birth control pills? Yes No

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control

Emergency Contact:
Name_____ Phone Number_____

Patient/Guardian Initials: _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement

I have reviewed a copy of this office's Notice of Privacy Practices and understand that a photo static copy of this document shall be considered as effective and valid as an original.

_____ _____ _____
{Please Print Name} {Signature} {Date}

Staff Note: _____

Financial Policies

Complete Care Dental (legal entity: Partners in Care Dentistry, LLC), “the Practice” or “We” must receive accurate insurance information at the time of the appointment. If not, patient(s) or the financially responsible party for the patient (“You” or “Your”) are required to pay in full for fees when services are rendered. You are responsible for paying deductibles and co-payments before or at the time of service. Actual amounts received from insurance plans may vary greatly from any estimate of benefits we may provide You. Regardless, You are responsible for paying all charges not covered by Your primary insurance plan. If the accuracy of any such estimate will impact Your decision as to the acceptance of a treatment proposal, You are encouraged to contact Your dental insurance carrier for any clarification from them before beginning treatment. We will submit a primary insurance claim for You up to two times per appointment. Any further insurance appeal becomes Your responsibility. Except for deductibles and co-payments, You are responsible for payment in full the sooner of: (A) when insurance makes payment on Your claim; and(B) 60 days from the date services are provided even if the insurance company has not paid.

It is important to understand that the contract regarding your dental benefits is between You, your employer, and your insurance company. The obligation You have with our Practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company.

Full payment of fees is due before or at the time service is rendered unless insurance filings are involved as described above. Payments can be made by cash, check or various charge cards accepted by the Practice. Finance charges on account balances due to the Practice accrue at a rate of 1.5% per month and are compounded each month that an account balance due the Practice remains. However, when insurance is filed, finance charges may be waived for the period that is the lesser of: (A) the time it takes to receive such insurance proceeds; and (B) 60 days from the date services are rendered. This monthly finance charge rate is subject to change without notice, but will not exceed rates allowed under applicable law.

If your insurance provider does not allow assignment of benefits (this is when the insurance company pays You directly, and will not send payment to the Practice), full payment of fees at time of service is required.

A service charge for returned checks will be assessed. Currently this fee is $30 and may change from time to time without notice. You may also be responsible, up to limitations set by law, for fees charged by collection agencies or attorneys in situations where they are involved in the collection of account balances. A service charge for failed appointments and appointments not cancelled with 24 business hours will be assessed. Currently this fee is $35 and may change from time to time without notice.

Acknowledgement and Agreement:
I authorize release of any information concerning my or my child’s health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I agree to pay in full all outstanding balances at the time work and/or services are completed. I recognize that my failure to pay my account in full after work and/or services are completed may result in my balance being placed with a collection agency and possible listing with the credit bureau(s).

I further agree, in order for the Practice to service the account or to collect any amounts I may owe, the Practice may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. The Practice may also contact me by sending text messages or emails, using any e-mail address I provide to the Practice. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

As the patient and / or the financially responsible party for the patient, I certify that I have read, understand, and agree to all terms of this Financial Policy. I further understand that a photo static copy of this form shall be considered as effective and valid as an original. I will hold the Practice or any of its employees harmless for any omissions I have made in completion of information. I authorize the Practice to release information regarding my treatment for purposes of filing for potential payment of benefits when applicable and I grant assignment of any such proceeds to the Practice.

_____ _____ _____
Signature Printed Name Date