Cedar Mountain Family Dentistry

Detions Information		Date:							
Patient Information		First Name:		Mic	Idle Initial				
				Middle Initial:					
Mailing Address: (Street)_		(City)		_(State)	(Zip)				
Birthday:	□ Male □ Female	□ Single □ Mar	rried D Widowed	Divorced					
Home Phone:	Work Phone:		Cell Phone:						
Email Address:			Do	you want text	t reminders?	□ Yes □ No			
Social Security Number:			Do y	ou want emai	il reminders?	🗆 Yes 🗖 No			
Occupation:	Emj	oloyer:]	Employer Pho	one:				
How did you hear about u	s? Insurance, Friend/Family, G	oogle, Internet, Other:							
In Case of Emergency Name:	<u>Contact</u>		Relationship:						
Home Phone:	Work Phon	e:							
Account Information									
Insurance Company:	ID	Number:		Group N	lumber:				
□ Person responsible for	this account is the same as al	bove							
Last Name:	Fi	Middle Initial:							
Mailing Address: (Street,	City, State, Zip)								
Birthday:	□ Male □ Female	Gingle G Marr	ied 🗖 Widowed 🕻	Divorced					
Home Phone:	Work Phon	Cell Phone:							
Email Address:									

Agreement & Consent

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or responsible Party Signature: X Date:

Physician Office Phone Date of last exam Yes No Ves No 1. Are you under medical treatment now? Are you pregnant or think you surgical operation or serious illness? 				PATIE	NT	MEDICAL H	IISTO	R	Y			
Yes No Yes No 1. Are you user medical treatment now? 0 6. Women Only 0 0 3. Have you ever been hospitalized for any surgical operation or serious illness? 0 may be pregnant? 0 0 3. Do you use any form of tobacco? 0 0 b) Are you nursing? 0 0 4. Do you have a persistent cough? 0 0 o) Are you taking birth control? 0 0 Please list any allergies (esp. Penicillin, Anesthetics, Aspirin):	Physician		Office Phone					Date of last exam				
2. Have you ever been hospitalized for any surgical operation or serious illness? a) Are you pregnant or think you surgical operation or serious illness? a) may be pregnant? a) 3. Do you use any form of tobacco? b) Are you nursing? c) 4. Do you have a persistent cough? c) Are you taking birth control? c) Please list any allergies (esp. Penicillin, Anesthetics, Aspirin):												
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Yes No Yes No High Blood Pressure I Rheumatic Fever I Sleep Apnea I Heart Attack I Cardiac Pacemaker I Arthritis I I Heart Attack I Mental Health Disorder I Glaucoma I I Heart Disease I Mental Health Disorder I Glaucoma I I Stroke I Autoimmune Disease I Liver Disease I I Osteoporosis I Low Blood Pressure I Asthma I I Joint Replacement I Cancer / Chemo / Radiation I Anemia I I Angina / Chest Pain Respiratory Problems I Tuberculosis I I Fainting / Seizures I Neurological Disorder I Emphysema I I High Cholesterol I GERD / Acid Re-flux I TMJ / TMD I I Kidney Disease I Hepatitis / Jaundice I Other I I <t< th=""><th>Please list any current</th><th>medic</th><th>ations_</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th>·</th></t<>	Please list any current	medic	ations_									·
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Diabetes Image: Component of the set of th	Heart Disease			Mental He	ealt	h Disorder				Glaucoma		
Osteoporosis Image: AIDS or HIV Infection Image: Eating Disorder Image: Eating Disorder Joint Replacement Image: Cancer / Chemo / Radiation Image: Eating Disorder Image: Eating Disorder Angina / Chest Pain Image: Eating Disorder Im	Stroke			Autoimm	une	Disease				Liver Disease		
Joint Replacement Cancer / Chemo / Radiation Anemia Anemia Image: Cancer / Chemo / Radiation Angina / Chest Pain Respiratory Problems Image: Cancer / Chemo / Radiation Image: Cancer / Chemo / Che	Diabetes			Low Bloc	d P	ressure				Asthma		
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jaw problems?Image: Image:									-			
8. Do you participate in athletics?]							
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I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Cedar Mountain Family Dentistry

Receipt of Notice of Privacy Practices-Written Acknowledgment Form

I, ______, have been offered a copy of Cedar Mountain Family Dentistry's Notice of Privacy Practices for review. (Also available on our web site).

Signature of Patient

Date

Cancellation and Payment Policies

Cancellation Policy

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time. Our office rarely runs behind - this is because we do not overbook appointments in anticipation of cancellations. We therefore strictly enforce our cancellation policy.

Our cancellation policy is as follows:

- \star A 24 hour notice is required.
- ★ The first no-show or short notice cancellation will result in a \$75.00 fee
- ★ The second no-show or short notice cancellation will result in a \$75.00 fee, and you will be placed on a same day only list. At that time you will be free to schedule a same day appointment with our office at anytime, but no appointment will be made in advance.

Payment Policy Contract

Patients are responsible for payment, co-payments and deductibles at time of service. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts. In the event our office is not contacted within 30 days of you receiving our last billing statement your account will be turned over to our collection agency.

In addition, I assign directly to Cedar Mountain Family Dentistry all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I also verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief. I authorize Cedar Mountain Family Dentistry to release my complete records to my insurance company in order to process my claim and for any other physicians or medical facilities that may be pertinent and necessary to care and treatment.

I______ have reviewed the above payment and cancellation policies.