City Point Dental – Patient Information Form

Patient Legal Name (First, MI, Last/ Preferred):	Date of Birth:	Sex:	Social Security No.
Street Address:	City:	State:	Zip Code:

Home Phone:	Cell Phone: Text messages, ok? Y or N	Email Address:

Primary Insurance:	Policy ID:	Policyholder Name:	Policyholder DOB:

Name of Emergency Contact:	Relationship to patient:	Phone number:

PATIENT OR RESPONSIBLE PARTY INFORMATION

Name:	Date of Birth:	Phone Number:	Social Security No.
Street Address:(If different from above)	City:	State:	Zip Code:

Employer Name:	Phone Number:

PEDIATRIC PATIENTS – Please list parents and name(s) and contact information for anyone who may bring a child to an appointment and have access to your child's medical record information.

FATHER:	Phone Number:
MOTHER:	Phone Number:

ADULT PATIENTS – Please list name(s) of anyone who may have access to your medical record information.

Name:	Relationship to patient:	Phone Number:
Name:	Relationship to patient:	Phone Number:

***I certify that I have read and understand the above and that the information given on this form is accurate.**

_____ _____

Signature of Patient or of Representative/Parent (Date)

_____ _____

Printed Name of Patient or of Patient's Representative/Parent) (Date)

Medical History

Are you under a physician's care now?	Yes	No
Have you ever been hospitalized or had a major operation?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No
Do you use tobacco?	Yes	No
Do you use controlled substances?	Yes	No
Are you taking any medications, pills, or drugs? Please list.		
Do you take or have you ever taken biophosponates? (ie. Fosomax/Actonel)	Yes	No
Are you on a special diet?	Yes	No

Women: Are you

Pregnant/trying to get pregnant	Yes	No	Taking oral contraceptives?	Yes	No	Nursing	Yes No

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic	metal
Local anesthetics	Latex	None		

Other (please explain)_____

Do you have, or have you had any of the following, Please circle if 'yes'.

AIDS/HIV Positive	Convulsions	Hepatitis A	Rheumatism
Alzheimer's Disease	Cortisone Medicine	Hepatitis B or C	Scarlet Fever
Anaphylaxis	Diabetes	Herpes	Shingles
Anemia	Drug Addiction	High Blood Pressure	Sickle Cell Disease
Angina Pectoris	Easily Winded	High Cholesterol	Sinus Trouble
Arthritis/Gout/Rheumatism	Emphysema	Hives or Rash	Special Diet
Artificial Heart Valve(s)	Epilepsy or Seizures	Hypoglycemia	Spina Bifida
Artificial Joint(s)	Excessive Bleeding	Irregular Heartbeat	Stomach/Intestinal issues
Aspirin Taken Daily	Excessive Thirst	Kidney Problems	Stroke

Do you have, or have you had any of the following, Please circle if 'yes'.

Asthma	Fainting Spells/Dizziness	Leukemia	Swelling of the Limbs
Back Problems	Frequent Cough	Liver Disease	Tonsillitis
Blood Disease	Frequent Diarrhea	Low Blood Pressure	Tuberculosis
Blood Transfusion	Frequent Headaches	Lung Disease	Tumors/Growths
Breathing Problem	Genital Herpes	Mitral Valve Prolapse	Ulcers
Bruise Easily	Glaucoma	Pain in Jaw Joints	Venereal Disease
Cancer	Hay Fever/Allergies	Parathyroid Disease	Yellow Jaundice
Chemotherapy	Heart Attack/Heart Failure	Psychiatric Care	
Chest Pains	Heart Murmur	Radiation Treatments	
Circulatory Problems	Heart Pacemaker	Recent Weight Loss	
Cold Sores/Fever Blisters	Heart Trouble/Disease	Renal Dialysis	
Congenital Heart Disorder	Hemophilia	Rheumatic Fever	

Have you ever had any serious illnesses not listed above? If yes, please explain._____

Have you ever responded adversely to medical or dental treatment? Yes No

If patient is a child, what is his/her weight? _____

Have you ever been advised to be premedicated prior to any dental procedure? Yes No

Is there anything else we should know about your medical history? _____

_____

Comments:

Dental History

Date of last dental exam/cleaning? _____

Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest dental concern? _____

I have verbally reviewed the medical/dental information above with the parent/guardian/ or patient named herein.

Staff/Dr. initials_____ **Date**_____

AUTHORIZATION AND RELEASE

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist/dental group insurance benefits, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Parent if minor _____Date_____

Notice of Privacy Practices

I have received a copy of the "Notice of Privacy Practices" for City Point Dental. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice (is posted in our office, on our website, and copies are available any time. I understand that I may ask questions to City Point Dental if I do not understand any information in the Notice of Privacy Practices. _____

Initials

Consent for Treatment, Assignment of Benefits & Financial Policies

- **Consent For Treatment**

  I authorize City Point Dental to provide dental treatment to myself of my dependent.

- **Assignment of Benefits**

  I request that payment of authorized insurance benefits be paid directly to City Point Dental for services provided under their care.

- **Release of Medical/Dental Information**

  I authorize City Point Dental to release necessary medical/dental information to my insurance company, its agents, or any third-party payer in order for payable benefits for these services to be determined.

- **Collection of Co-Pays and Deductibles**

  Per our agreement with your insurance carriers, you are required to pay any applicable estimated copayments at the time of service. Please keep in mind that any treatment plans presented to you in our office is an estimation of benefits and NOT a guarantee of payment. If insurance pays less than what our office estimated, then it would result in an additional patient responsibility. Unfortunately, we have no control over your insurance benefits and cannot guarantee exact payment.

- **Financial Responsibility**

  I understand that City Point Dental will file my insurance (if any) as a courtesy: however, I am responsible for full payment of all charges and copays. We accept checks, cash, all forms of credit cards and DON'T OFFER ANY IN-HOUSE PAYMENT PLANS at this time. If you're looking for a form of payment plan, we do accept Care Credit, which is a credit card offer by Synchrony Bank and is NOT an in-house credit program offered by City Point Dental. You may apply for the Care-credit health-care credit card and if approved, use it at City Point Dental's office. However, the Care-credit credit card agreement is between you and Synchrony Bank. Subject to credit approval. Our office will charge $35 for any check that is returned for insufficient funds.

- **Missed Appointments**

  We value our chair time and our patients and would like to ensure that we are appointing our patients to their day/time requests as best as we can. Please give our office a call at least 24 hours in advance if you need to cancel or make any changes to your appointment: failure to do so may result in a $50 "no show/failed" fee.

I have read the above statements and I understand my responsibilities. I acknowledge that City Point Dental will scan this document and destroy the original, and agree the scanned document is the same as the original.

_____ _____

Signature of Patient or Responsible Party (Date)

_____ _____

Printed Name of Patient or Responsible Party (Date)

CITY POINT
DENTAL

Photo Release Form

I hereby grant permission to City Point Dental to use photographs and/or video recordings including images of me both internally and externally to promote the practice. These images could be used in print and digital media formats including print publications, websites, e-marketing, posters banners, advertising, film, social media, teaching and research purposes.

I understand that I may revoke this authorization at any time by notifying info@citypointdental.com in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

_____ Date _____

(Signature of Adult, or Guardian of Children under age 18)

Name _____

Address _____

_____

Phone _____

Email Address _____

Thank you!