City Point Dental – Patient Update Form

Patient Name (First, MI, Last):	Date of Birth:	Sex:

Street Address:	City:	State:	Zip Code:

Home Phone:	Cell Phone: Text Messages ok: Y or N	Email Address:

DENTAL INSURANCE INFORMATION (*IF DIFFERENT FROM YOUR LAST VISIT*)

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

PATIENT MEDICAL HISTORY

Have there been any medical changes since your last updated forms? Y or N

If yes, please explain:

Please list any allergies to any meds:

Please list any medications you're currently taking or provide our staff with a list if you already have one available:

____Taken for ____

____Taken for ____

____Taken for ____

____Taken for ____

____Taken for____

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)

Patient Name: ________________________________

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 CareCredit healthcare credit card and if approved, use it at City Point Dental's office. However, the CareCredit 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)

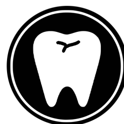

Photo Release Form

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!