# CardinalDental

# NEW PATIENT INFORMATION

Anything we can do to make your first visit more enjoyable? _____

How would you rate your smile from 1-10 (poor-great)? _____ How long since your last dental visit? _____

What is the purpose of your visit? _____

What would you change about your smile? _____

Would you be interested In whitening, veneers, or straightening teeth? ◯ Yes ◯ No

How did you hear about us? ☐Referral: _____ ☐Insurance ☐Yelp ☐Google ☐Facebook ☐Instagram ☐Print Ad

| **Patient Information** | **Responsible Party** (if someone other than the patient) |
|---|---|
| Name: _____ | Name: _____ |
| Street: _____ | Street: _____ |
| City/State/Zip: _____ | City/State/Zip: _____ |
| Home Phone: _____ | Home Phone: _____ |
| Cell Phone: _____ | Cell Phone: _____ |
| Email Address: _____ | Email Address: _____ |
| DOB: _____ | DOB: _____ |
| SSN: _____ | SSN: _____ |
| Driver's License: _____ | Driver's License: _____ |
| Gender: ◯ M ◯ F | Gender: ◯ M ◯ F |
| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed |

| **Insurance Information** | **Secondary Insurance Information** |
|---|---|
| (Skip down to subscriber ID# if the patient is the subscriber) | |
| Subscriber Name: _____ | Subscriber Name: _____ |
| Subscriber Home: _____ | Subscriber Home: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Subscriber Phone: _____ | Subscriber Phone: _____ |
| Subscriber DOB: _____ | Subscriber DOB: _____ |
| Subscriber ID# or SSN: _____ | Subscriber ID# or SSN: _____ |
| Insurance Company Name: _____ | Insurance Company Name: _____ |
| _____ | _____ |
| Insurance Phone: _____ | Insurance Phone: _____ |
| Employer Name: _____ | Employer Name: _____ |

In the case of an emergency please contact the following individual: _____

Phone Number: _____ Relationship: _____

# CardinalDental

# MEDICAL HISTORY

Have you ever been hospitalized or had a major operation? ◯ Y ◯ N If Yes, Details: _____

_____

Are you under a physician's care now? ◯ Y ◯ N If Yes, Name: _____

Address: _____ Phone: _____ Fax: _____

Have you ever had a serious head or neck injury? ◯ Y ◯ N If Yes, Details: _____

_____

Are you taking any medications, pills or drugs? ◯ Y ◯ N If Yes, Details: _____

_____

Have you ever taken Phen-Fen or Redux? ◯ Y ◯ N If Yes, Details: _____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Y ◯ N

If Yes, Details: _____

Do you use tobacco? ◯ Y ◯ N If Yes, Details: _____

Are you taking blood thinners? ◯ Y ◯ N If Yes, Details: _____

Do you use controlled substances? ◯ Y ◯ N If Yes, Details: _____

Women: Are you... ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

**Are you allergic to any of the following?** ☐ No known drug allergies

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other, Explain: _____

**Do you have, or have you had, any of the following? (please answer yes or no to each condition)**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ◯Y ◯N | Diabetes | ◯Y ◯N | Heart Disease | ◯Y ◯N | Psychiatric Care | ◯Y ◯N |
| Alzheimer's Disease | ◯Y ◯N | Drug Addiction | ◯Y ◯N | Hepatitis ☐A ☐B ☐C | ◯Y ◯N | Radiation Tx | ◯Y ◯N |
| Anaphylaxis | ◯Y ◯N | Emphysema | ◯Y ◯N | Herpes | ◯Y ◯N | Rheumatic Fever | ◯Y ◯N |
| Anemia | ◯Y ◯N | Epilepsy or Seizures | ◯Y ◯N | High Blood Pressure | ◯Y ◯N | Sinus Trouble | ◯Y ◯N |
| Angina | ◯Y ◯N | Excessive Bleeding | ◯Y ◯N | High Cholesterol | ◯Y ◯N | Stroke | ◯Y ◯N |
| Arthritis/Gout | ◯Y ◯N | Fainting/Dizziness | ◯Y ◯N | Hypoglycemia | ◯Y ◯N | Swelling of Limbs | ◯Y ◯N |
| Artificial Heart Valve | ◯Y ◯N | Frequent Cough | ◯Y ◯N | Irregular Heartbeat | ◯Y ◯N | Thyroid Disease | ◯Y ◯N |
| Artificial Joint | ◯Y ◯N | Frequent Headaches | ◯Y ◯N | Kidney Disease | ◯Y ◯N | Tuberculosis | ◯Y ◯N |
| Asthma | ◯Y ◯N | Glaucoma | ◯Y ◯N | Liver Disease | ◯Y ◯N | Tumors or Growths | ◯Y ◯N |
| Bleeding problems | ◯Y ◯N | Hay Fever | ◯Y ◯N | Low Blood Pressure | ◯Y ◯N | Ulcers | ◯Y ◯N |
| Cancer | ◯Y ◯N | Heart Attack/Failure | ◯Y ◯N | Lung Disease | ◯Y ◯N | Venereal Disease | ◯Y ◯N |
| Chemotherapy | ◯Y ◯N | Heart Pacemaker | ◯Y ◯N | Osteoporosis | ◯Y ◯N | Yellow Jaundice | ◯Y ◯N |
| Cold Sores | ◯Y ◯N | Heart Defect | ◯Y ◯N | Pain in Jaw Joints | ◯Y ◯N | | |

Have you ever had any serious illness not listed? ◯ Y ◯ N If Yes, Details: _____

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

_____ _____

**Doctor Signature** **Date**

_____ _____

**Signature of Patient / Parent or Guardian** **Date**

# INFORMED CONSENT
# RADIOGRAPH CONSENT
# DENTAL MATERIALS
# PRIVACY PRACTICES

## INFORMED CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning any invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is risk associated with dental procedures and all of your questions have been answered.

Dental treatment and dental procedures are not to be taken for granted as routine or without the risk of complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are many variables involved, some predictable and others not. Complications in dentistry are very low but they do exist. Individuals who are contemplating treatment should be aware of this prior to consenting.

**I HAVE READ, UNDERSTAND, AND CONSENT TO DENTAL TREATMENTS** _____
Initials

## RADIOGRAPH CONSENT

Radiographs (commonly know as x-rays) will be necessary before any diagnosis can be finalized. X-rays are used to diagnose 1) extent of bone loss associated with periodontal disease 2) decay between teeth 3) health of the tooth pulp 4) integrity of root canal fillings 5) verify tooth or root structure 6) Impacted wisdom teeth or extra teeth 7) pathological root resorption or decay 8) bone pathology 9) need for orthopedic/ orthodontic treatment.

No invasive dental treatment will be started without current x-rays of the teeth to be worked on.

**Children:** If any decay or dental infection (abscess) is obvious on visual inspection, x-rays will be necessary to assess the extent of damage to the tooth structure. If your child is uncooperative, the child will be referred to a pediatric dentist for treatment. X-rays are recommended for children 5 years and older but they may be suggested as early as 3 years if we suspect decay.

**Pregnant women:** X-RAYS WILL BE AVOIDED UNLESS IT IS AN EMERGENCY. Please inform us at once if you think you are pregnant, and x-rays will be postponed.

**Radiation Exposure:** This office uses digital radiographs which minimizes your exposure. The amount of exposure from a panorex and FMX is equivalent to being out in the sun for 4 days (UCLA study).

◯ **I CONSENT TO HAVE RADIOGRAPHS (X-RAYS) TAKEN**

◯ **I REFUSE TO HAVE RADIOGRAPHS (X-RAYS) TAKEN AT THIS TIME**

I UNDERSTAND THAT IF I REFUSE TO TAKE X-RAYS, A COMPLETE AND THOROUGH DIAGNOSIS IS NOT POSSIBLE. NO DENTAL TREATMENT INCLUDING CLEANINGS WILL BE DONE UNLESS I PROVIDE X-RAYS FROM MY PREVIOUS DENTAL OFFICE DATED LESS THAN ONE YEAR OLD. I WILL NOT HOLD THE DENTIST OR STAFF RESPONSIBLE FOR NOT INFORMING ME OF ANY DENTAL CONDITIONS I MAY HAVE IF I REFUSE TO TAKE X-RAYS. I FURTHER UNDERSTAND THAT IF I HAVE BEEN A PATIENT OF THIS PRACTICE FOR OVER TWO YEARS AND CONTINUE TO REFUSE TAKING X-RAYS, CARDINAL DENTAL RESERVES THE RIGHT TO DISMISS ME FROM THE PRACTICE. _____
Initials

## DENTAL MATERIALS FACT SHEET

The Dental board of California has posted this fact sheet here: https://www.dbc.ca.gov/formspubs/pub_dmfs_english_webview.pdf

You can also click **HERE** to open a link to read, download, or print this fact sheet. If you would like us to provide you with a physical copy of the fact sheet just ask during your appointment.

## NOTICE OF PRIVACY PRACTICES

Click **HERE** to open a link to read, download, or print Cardinal Dental's Notice of Privacy Practices.

If you would like us to provide you with a physical copy of this notice just ask during your appointment.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

**I HAVE READ AND UNDERSTAND CARDINAL DENTAL'S INFORMED CONSENT AND RADIOGRAPH CONSENT.**
**I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE DENTAL MATERIALS FACT SHEET AND NOTICE OF PRIVACY PRACTICES.**

_____ _____

Signature of Patient / Parent or Guardian Date

CardinalDental

# OFFICE POLICIES

## FINANCIAL POLICY

**Patients with Insurance Coverage:**

Please understand that your insurance policy is a contract between you and your insurance company. Cardinal Dental is not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments of your account. We can request a pre-estimate of benefits from your insurance carrier if you request to do so. Routine treatments are generally performed without submitting a request of pre-estimate of benefits. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to the treatment. If your insurance company has not paid the claim within 60 days, the balance will be automatically transferred to you. In some cases, insurance carrier may pay for alternative benefits other than the treatment performed, or deny payment of certain claims. In this case, you are responsible to pay for the difference or remaining balance. Even if you have dual coverage (which is possible when you and your spouse both have insurance) there may still be a portion that is your responsibility. All procedures involving lab work will require at least 50% down payment, then the remaining 50% balance will be due as treatment progresses. The balance must be paid before final insertion. If you are having extensive treatment over a period of time, we request payments during the course of treatment. Our financial coordinator will assist you in arranging a payment schedule.

**Patients without Insurance Coverage:**

Patients without insurance coverage are required to pay for services as rendered. We accept Cash, Check, Personal Credit Cards (Visa, MasterCard, Discover, American Express), Flexible Spending Plans/FSA and third party finance groups (Care Credit).

## BILLING POLICY

Checks returned unpaid from the bank are subject to $35.00 service fee.

Patients will receive a monthly statement/bill for all balances exceeding 30 days. Unless insurance claims are pending, patients will be required to pay the balance in full.

Patients on in-house payment arrangements will be required to pay (per agreement) monthly obligation until balance is paid in full. If account is delinquent more than 90 days, the full balance will be transferred to the patient's account and due in full within the next 30 days.

Patients on automatic credit card/debit card debit will provide two forms of credit cards and will be required to keep both accounts active until patient's account balance is paid in full. Cardinal Dental is given authority by account holder to (per agreement) submit a monthly transaction on their authorized card to cover the monthly financial payment. If account is delinquent more than 90 days, the full balance will be transferred to the patient's account and due in full within the next 30 days.

If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

## APPOINTMENT CANCELLATION POLICY

We require a 48 hour notice in the event you need to reschedule or cancel your appointment. If you fail to give us a 48 hour notice there will be a $50 cancellation fee unless you inform us of an emergency or illness preventing you from making the appointment.

**We welcome you to our office and want to provide you with the best care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.**

**I HAVE READ AND UNDERSTAND CARDINAL DENTAL'S FINANCIAL POLICY, BILLING POLICY, AND APPOINTMENT CANCELLATION POLICY**

Signature of Patient / Parent or Guardian

Date