City Dental DC
serving over 20 years

Patient Information (Confidential)

Name: _____ Nickname: _____ **Male ❑ Female ❑**

Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ **Cell Phone:** _____

Soc. Sec. #_____ Employer: _____ **Birth Date:** _____

E-mail Address: _____

Emergency Contact Name: _____ **Their Phone:** _ _____

How would you like to be reminded of your appointment: ❑ E-mail ❑ Text ❑ Cell ❑ Work ❑ Home

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

How did you hear about our office? ❑ Insurance ❑ Internet ❑ Mailer ❑ Referral ❑ Magazine ❑ Movie Theatre

❑ Newspaper (Which one): _____

Whom may we thank for referring you_____ (They build credit for prizes)

- Please read all notices in the waiting room. Copies of any of these documents will be provided (when requested) including: **Cancellation Policy** and associated fees, our **HIPPA Notice of Privacy Practices** and **Authorization for release of identifying health information**.
- Offices are Audio & Video monitored & recorded 24 hours a day.
- We will be using a digital signature for all future transactions. You agree that this is the same as a written signature.
- My medical information will be entered into the computer system directly (Fast Check-in) and will be updated by me each time I come in for a recall, or upon a change in my medical history or medication, or upon request of this office.
- Our office is **OSHA, HIPPA** and **Red Flag Rule** compliant. Copy of all forms are available upon request.
- I authorize the dentist, hygienist, and assistants to examine, take radiographs, to do any and all necessary treatment on me.
- I allow my photos or X-rays to be shown to other patients for teaching purposes.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

For your convenience, we offer the following methods of payment:
Debit Card • MasterCard • Visa • American Express • Check

Payment is expected at time of service.

- **Cancellation Policy:** I understand that I will pay a fee for either BROKEN APPOINTMENTS or APPOINTMENTS CANCELLED /CHANGED/RESCHEDULED with less than two (2) Business Days notice. Leaving messages does not constitute contact / communication. (Ask receptionist for current fee or see posted sign.) Certain longer appointments, such as crowns, onlays, root canals, implants, extractions, scaling & root planing, etc… may require a non-refundable deposit upon making the appointment (usually it's approximately 25% of the estimated out of pocket cost). This contract between City Dental DC and me shall not become effective until it is signed and any initial deposit amount due has been paid. At the time the contract takes effect DentalBug shall reserve the date and time agreed upon. For this reason, in the event that I cancel the contract for any reason, all monies paid shall be forfeited by me and retained by City Dental DC in order to offset its loss of business. My failure to pay the fees may result in dismissal from the practice, inactivation of my chart, delinquent and collection charges.

- **Delinquency Policy:** I understand if my account is delinquent, I will be charged an additional 33% to cover collection expenses and a 1.8% monthly finance charge from time the services are rendered. I also understand that not all procedures are covered by my insurance. I am responsible for any amount not covered by my insurance, including the payment of procedures scheduled but cancelled after the doctor has commenced work and/or the doctor has set aside the time for the procedure and I cancel.

- DentalBug verifies my insurance benefits as a courtesy and it is my responsibility to know my plan benefits.

- If your insurance has changed please notify us two (2) business days in advance so we can get an updated breakdown. If we are unable to verify your insurance, then you will need to pay out of pocket and process your own insurance, using the receipt from that day's visit. If you choose to reschedule until it is verified, then the Cancellation policy takes effect.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam:_____

Do your gums bleed while brushing your teeth?	❑ Yes	❑ No	Do you have frequent headaches?	❑ Yes	❑ No
Are your teeth sensitive to hot or cold liquids/foods?	❑ Yes	❑ No	Do you clench or grind your teeth?	❑ Yes	❑ No
Are your teeth sensitive to sweet or sour liquids/foods?	❑ Yes	❑ No	Do you bite your lips or cheeks frequently?	❑ Yes	❑ No
Do you feel pain in any of your teeth?	❑ Yes	❑ No	Have you ever had any difficult extractions?	❑ Yes	❑ No
Do you have any sores or lumps in or near your teeth?	❑ Yes	❑ No	Have you ever had any prolonged bleeding		
Have you had any head neck or jaw injuries?	❑ Yes	❑ No	following extractions?	❑ Yes	❑ No
Have you ever experienced any of the following			Have you had any orthodontic treatment?	❑ Yes	❑ No
problems in your jaw?	❑ Yes	❑ No	Do you wear dentures or partials?	❑ Yes	❑ No
Clicking	❑ Yes	❑ No	If yes, date of placement:_____		
Pain (joint, ear, side of face)	❑ Yes	❑ No	Have you ever received oral hygiene instructions		
Difficulty in opening or closing	❑ Yes	❑ No	regarding the care of your teeth and gums?	❑ Yes	❑ No
Difficulty in chewing	❑ Yes	❑ No	Do you like your smile?	❑ Yes	❑ No

I certify that I have read and understand all of the above and that I have answered all of the questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me, or my child, during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or 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 including cancellation fees as stated above.

_____ _____

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