Cambrian Specialty Group

3535 Ross Ave. Suite # 302

Patient Information Form

Name: _____ Age: _____ Birth date: _____ Sex: _____
Last First Middle Initial

Social Security# _____ Driver's License: _____ State: _____

Home Address: _____ Apt# _____ City: _____ State: _____ Zip: _____

Home# _____ Cell# _____ Email: _____

Employer: _____ Occupation: _____ Marital Status: _____

General Dentist: _____ Phone# _____

Whom may we thank for referring you to us? _____ ***Phone#*** _____

Insurance Information

Primary Dental Insurance: _____ Employer: _____

Name of subscriber: _____ Date of birth: _____

Social security# _____ ID# _____

Secondary Dental Insurance: _____ Employer: _____

Name of subscriber: _____ Date of birth: _____

Social security# _____ ID# _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone# _____
Last First

Medical History

Patient Name: _____

What is the reason for your visit today? _____

Have you been hospitalized or has emergency treatment in a hospital in the past 5 years?
Why? _____

Have you been under a doctor's care in the past 2 years?
Why? _____

Have you had problems prior dental treatment? Yes or No
Do you use tobacco regularly? Yes or No
Are you allergic to latex? Yes or No

In the case that any medications are required for treatment, we do need a pharmacy on file

Pharmacy Name: _____ Phone# _____

Are you currently taking the following medications?

Blood Thinner	Yes or No
Insulin	Yes or No
Aspirin	Yes or No
Heart Medication	Yes or No
Blood Pressure	Yes or No
Lung/Breathing	Yes or No
Cortisone/steroid	Yes or No
Nitroglycerine	Yes or No

Are you currently taking any Medications? Yes or No
If yes, please list below,
_____

Are you allergic to any Medications? Yes or No
If yes, please list:
Medicine: _____ Reaction: _____
Medicine: _____ Reaction: _____
Other(s): _____

Do you have or have you had?

Heart Problem	Yes or No	Lung Problem	Yes or No	Diabetes	Yes or No
Heart Murmur	Yes or No	Venereal Disease	Yes or No	Ulcers	Yes or No
Rheumatic Fever	Yes or No	Sinus Problem	Yes or No	Arthritis	Yes or No
Scarlet Fever	Yes or No	Liver Disease	Yes or No	Stroke	Yes or No
High Blood Pressure	Yes or No	Hepatitis/Jaundice A, B, C	Yes or No	Cancer	Yes or No
HIV/ARC/AIDS	Yes or No	Alcohol/Drug Problem	Yes or No	Radiation	Yes or No
Blood Disease/Anemia	Yes or No	Psychiatric Treatment	Yes or No	Asthma	Yes or No
Kidney Disease	Yes or No	Epilepsy/Seizures	Yes or No		

Have you ever taken any of the group collectively referred to as **"fen-phen"?** These include a combination of **Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine), Fosamax, Actonel or Boniva, Bisphosphonate?** Yes or No

Have you had a placement of an artificial joint, prosthetic heart valve, implant or pacemaker? Yes or No
If yes, please list: _____

Are you subject to prolonged bleeding? Yes or No

Do you have difficulty opening your mouth or popping/ clicking or pain in your jaw joints **(TMJ)?** Yes or No
If yes, please list: _____

Do you have any other conditions that we should know about? _____

WOMAN ONLY: Are you or could you be pregnant? Nursing? (please clarify) Yes or No _____
Are you taking birth control pills? Yes or No

Physician's Name: _____ **Phone #** _____

Patient/Parent/Guardian Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

OFFICE POLICIES

LATE ARRIVAL POLICY

A grace period of 10 minutes will be permitted for unforeseen delays a patient may encounter while traveling to our clinic for their appointment. Arriving more than 10 minutes late might result in cancellation and rescheduling for a later date. This process will ensure patients that do arrive on time are seen in a timely manner.

LAST MINUTE CANCELLATIONS OR MISSED APPOINTMENTS

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all our patients. In return, we ask that patients make every effort not to change reserved appointments. When appointments are missed or little notice is given, other patients who need an appointment have to wait.
If an appointment needs to be changed, we request a week notice. If a week notice is not possible, ***WE REQUIRE ATLEAST 48-HOURS NOTICE FOR ALL APPOINTMENTS SO THAT WE MAY ACCOMMODATE OTHER PATIENTS.*** In addition, A ***CONFIRMATION IS REQUIRED*** for each appointment. Failure to confirm any appointments will result in a cancellation. A charge of **$75.00** will be applied to broken or missed appointments without 48hour notification; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without payment of this fee.

FOR PATIENTS WITH DENTAL INSURANCE COVERAGE

Most insurance plans are not designed to pay the entire fee. Many policies have deductibles and co-payment clauses that limit their liability. We check each patient's insurance and are given ***ESTIMATED*** amounts as far as what is remaining on the policy and the percentage of coverage; all information given from insurance companies is subject to review and is ***ONLY AN ESTIMATION***. Therefore, we require that the estimated portion, not covered by insurance, be paid at the time each is rendered. If necessary or requested, we will submit a pre authorization to' your insurance coverage.

In the event there is an overpayment, we Will either credit your account or refund the overpayment to you, whichever you prefer. Also, if there is any remaining balance due aner the insurance portion has been paid, ***YOU WILL BE RESPONSIBLE FOR PAYING THE BALANCE WITHIN 30 DAYS*** All returned checks are subject to **$50.00** service charge that will be added to your account balance.

If you should have any questions regarding your dental benefits, our staff will be happy to assist you to the best of our abilities in determining your coverage. Remember that your dental insurance is an agreement between you and your insurance company. Due to the Privacy Act, many questions must be answered by the policy holder and given directly to the insurance company.

The goal of our office is to constantly strive to provide you with the best dental care available today. We are proud of the quality of services that we provide and we are open to suggestions. However, in case of any grievance, the patient or patient's responsible party agrees to pay all cost and reasonable attorney fees if suit were instituted here under.

THANK YOU FOR YOUR COOPERATION!

Patient/ Parent Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____ [full name], have received a copy of the _____

[name of practice] Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to patient _____

For Program Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)