CACTUS POINT DENTAL

PATIENT REGISTRATION FORM

Date form filled out: ___/___/_____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: ____ / ____ / _____

Preferred Name: _____

Address: _____ Cell Phone: _____

_____

City: _____State: _____ Zipcode: _____ Home Phone: _____

Email Address: _____ SSN: _____

Marital Status: _____ Sex: _____

Preferred contact method: ☐ TEXT ☐ EMAIL ☐ PHONE CALL

Please provide how you were referred to Cactus Point Dental: _____

Guarantor (if different than patient):

Guarantor Name: _____ Date of Birth: ____ / ____ / _____

Address: _____ Cell Phone: _____

City: _____State: _____ Zipcode: _____ Home Phone: _____

Email Address: _____ SSN: _____

DENTAL INSURANCE INFORMATION:

Subscriber Name: _____ Date of Birth: ____ / ____ / _____

Relationship to Patient: Spouse/Life Partner/Child (circle one)

Dental Insurance Company: _____ Phone number: _____

Subscriber ID #: _____ Group #: _____

Group Name: _____

Do you have any dental concerns you would like addressed at this visit? _____

_____

Is there anything you would like to change about your smile? _____

_____

Medical History

Patient Name: Birth Date: Date:

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please list:_____

_____

_____

Are you taking any blood thinners? ☐ Yes ☐ No If yes, please list:_____

Do you require premedication? ☐ Yes ☐ No If yes, please list:_____

Do you use tobacco or vape? ☐ Yes ☐ No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Asthma/COPP	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Excessive Thirst	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin	☐ Amoxicillin or Penicillin	☐ Codeine	☐ Acrylic	☐ Metal
☐ Iodine	☐ Local Anesthetics	☐ Sulfa Drugs	☐ Latex	☐ Other

If other, please list:

Women: Are you… ☐ Pregnant/Trying to get pregnant ☐ Nursing? ☐ Taking Oral Contraceptives?

Comments:

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.

Signature of Patient, Parent, or Guardian:

X_____ Date:_____

Signature of Doctor:

X_____ Date:_____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

Authorization for release of Personal Health Information covering the period of health care.
In addition to the authorization for release of my protected health information, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient's Name: _____

Signature: _____ Date: _____

If patient has a Power of Attorney: I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (''PHI'') described below to my agent identified in my durable power of attorney for health care named:

_____.

HOURS OF OPERATION & CANCELATION POLICY

Monday-Thursday 8:30am-5:00pm

A minimum $50.00 fee will be charged to your account for broken appointments and appointments canceled without 24 business hours prior notice. Evenings, Nights, Weekends and holidays are not considered business hours.

FINANCIAL INFORMATION

We are committed to providing you with the best possible dental care. In order to begin a long lasting, professional relationship, we ask for your understanding and cooperation with our financial policy. We will submit claims to your dental insurance company on your behalf. All estimates for treatment are an estimate and NOT a guarantee of payment until your claims have reconciled.

ESTIMATED copayments will be due at time of service. We will submit claim(s) to your dental insurance company and apply payments received based on their explanation of benefits (EOB). Any remaining balance after insurance payment has been processed will be due upon receipt of statement. Each insurance policy is specific to the group/patient and we will do our best to estimate/coordinate benefits for each appointment based on an insurance breakdown received from your insurance company.

Treatment will be diagnosed and recommended based on dental necessity. This recommendation may be outside of your employer-selected coverage. It is our responsibility to offer the best care to our patient's and not limit this care based on insurance coverage.

Prosthetic cases (crown, bridge, veneers, etc.) and whitening trays will not be delivered until final payment has been received.

ACCEPTED FORMS OF PAYMENT: Visa, MasterCard, American Express, Discover, Check, Cash, Cherry, Sunbit. A service charge of 3.5% will be applied to credit card payments. No fees applied for debit, cash, or check.

FINANCING: We accept Cherry/Sunbit for monthly payments up to 72 months (based on amount). Additional payment arrangements in-office may be subject to a finance charge.

Patient Name (printed): _____ Date: _____

Patient Signature: _____ Date: _____