PATIENT INFORMATION

GENERAL INFORMATION

Patient First Name _____Middle Initial ___Last Name _____Nickname_____
□ Male □ Female Date of Birth _____ Social Security Number _____
Address _____ City _____ State _____ ZIP _____
Email_____ Home Phone _____Cell Phone _____
Employer_____ Occupation_____ Work Phone _____
Married □ Single □ Divorced □ Spouse's Name: _____
Emergency Contact _____ Relationship _____ Phone # _____

IF PATIENT IS A MINOR

Responsible Party _____ Relationship to Patient _____

HOW DID YOU HEAR ABOUT US?

□ Social Media □ Insurance □ Website □ Internet □ Family/Friend/Coworker □ Other

Who may we thank for your visit today? _____

COMMUNICATION

Cumberland Pointe Dental has permission to contact me with appointment reminders or other communication via the following (check all that apply):

□ Text □ Email Preferred Phone #: □ Home □ Cell □ Work

DENTAL INSURANCE INFORMATION

Primary Insurance Information
Insured's Name _____
Insured's Employer _____
Insured's DOB _____
Insurance Company _____
Insurance Phone # _____
ID # _____ Group # _____

Secondary Insurance Information (if applicable)
Insured's Name _____
Insured's Employer _____
Insured's DOB _____
Insurance Company _____
Insurance Phone # _____
ID # _____ Group # _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received/been offered a copy of the office's Notice of Privacy Practices.

I authorize the following person(s) to have access to my protected health information covered under the Privacy Practices:

Name (Printed)_____ Relationship _____
Name (Printed)_____ Relationship _____
Name (Printed) _____ Relationship _____

SIGNATURE

Patient Name (Printed) _____
Patient/Guardian Signature _____ Date _____

DENTAL HEALTH HISTORY

Patient Name _____Birthdate _____
Address _____City _____State_____ Zip _____
Phone _____ Email _____ □ Male □ Female

DENTAL HISTORY

Reason for Today's Visit: _____ Date of last cleaning:_____
Former Dentist _____Date of last dental x-rays: _____

Check (√) if you have had problems with any of the following:

□ Bad Breath	□ Grinding teeth/Jaw pain	□ Sensitivity
□ Bleeding gums	□ Loose teeth	□ Broken teeth/fillings
□ Clicking or popping jaw	□ Periodontal treatment	□ Sores/growths in mouth
□ Dry mouth	□ Food collection between teeth	□ Discolored teeth
□ Crowded teeth	□ Spaces between teeth	□ Missing teeth

How often do you floss? _____ How often do you brush? _____
Is there anything you would like to change about your smile? _____

MEDICAL HISTORY

Physician's Name _____ Date of last Visit _____
Have you had a serious illness or hospitalization in the past 5 years? □ YES □ NO
If yes, explain _____
Have you ever taken any bisphosphonate medications? □ YES □ NO
Are you taking any blood thinner medications? □ YES □ NO
Women: Are you pregnant? □ YES □ NO Nursing? □ YES □ NO
Do you use: Tobacco □ YES □ NO Type _____ Frequency _____
Alcohol □ YES □ NO Frequency_____
Other Drugs □ YES □ NO Type_____ Frequency _____

Check (√) if you have or have had any of the following:

□ Anemia	□ Cancer (Type _____)	□ Heart Problems	□ Pacemaker
□ Anxiety	□ Depression	□ Heart Surgery	□ Respiratory Disease
□ Arthritis	□ Diabetes	□ Hepatitis	□ Seizures
□ Artificial Heart Valve	□ Fainting	□ High/Low Blood Pressure	□ Shortness of Breath
□ Artificial Joints	□ GERD	□ HIV/AIDS	□ Stomach Ulcers
□ Asthma	□ Glaucoma	□ HPV	□ Stroke
□ Bleed easily	□ Headaches	□ Kidney Disease	□ Thyroid Problems
□ Blood disorders	□ Heart Attack	□ Liver Disease	□ Tuberculosis

□Other _____

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____

ALLERGIES

□ Aspirin	□ Penicillin
□ Advil	□ Sulfa
□ Codeine	□ Latex
□ Local Anesthetic	□ Other _____

SIGNATURE

Patient/Guardian Signature_____ Date:_____

ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all dental benefits, including major dental benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other dental plan to issue payment check(s) directly to Cumberland Pointe Dental for dental services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Cumberland Pointe Dental to (1) release any information necessary to insurance carriers regarding my treatments; (2) process insurance claims generated during examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested dental services from Cumberland Pointe Dental on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for all charges incurred during the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Signature Date