CAI DENTISTRY

PATIENT REGISTRATION

Patient's name ____ Date of Birth ___________ Single/ Married
Sex:_______________ If minor, name of legal guardian____________________________________
Home #____________________ Mobile # _______________________ Work #____________________
Email_________________________________
Address/ Mailing Address:____ City
____________________State ________ Zip _______________ Employer __________________________________
Whom may we thank for referring you to our office?
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INSURANCE INFORMATION: Not covered by dental insurance? **YES**____ **NO**_____
Your SS# : _____________________ or Member ID#____
Dental Insurance_________________ Group number___________
Covered by spouse's insurance? **YES _____ NO______**
Spouse's Name ________________________________ Spouse's dental insurance company
_______________________ Group number __________________ Spouse's birthday ______________________ SS# or Member ID# ___________________________

MEDICAL HISTORY

Do you have, or have you had any of the following? (Please check any that apply)

- ☐ Blood Problems (Anemia)
- ☐ Blood transfusion
- ☐ Heart problems
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Heart Pacemaker
- ☐ Stroke
- ☐ Bone or joint problems
- ☐ Artificial joint or valves
- ☐ High or low blood pressure (circle one)
- ☐ High Cholesterol
- ☐ Tuberculosis or other lung problems
- ☐ Kidney disease
- ☐ Hepatitis, jaundice or other liver disease
- ☐ Diabetes TYPE 1 or TYPE 2
- ☐ Epilepsy or Neurological disorders
- ☐ Thyroid problems
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Cancer/Tumor
- ☐ Abnormal bleeding after any surgery (heavy bleeder)
- ☐ Hay fever or sinus trouble
- ☐ Allergies
- ☐ Asthma

Are you required to Pre-medicate before any dental treatment? Yes___ No___

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin

Other:_________________________________

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners e.g. Coumadin)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin other diabetes drugs
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Natural supplements

Other:________________________________

Women:

Are you pregnant or plan to become pregnant? Yes___ No__

Taking hormones or contraceptives? Yes__ No___

Do you smoke, vape or use tobacco? Yes__ No___

Name of your primary medical physician: ___________________________

Phone#___________________________ **Signature**_____________________ **Date**___________________

FINANCIAL INFORMATION –PLEASE READ CAREFULLY

It is the goal of our practice to provide not only the finest care available, but also to provide financial services that do not cause undue hardships. Patients will be scheduled for treatment after financial arrangements are made with our Financial Associates regarding all treatment. OUR FINANCIAL ASSOCIATES ARE AVAILABLE TO ANSWER ANY QUESTIONS YOU HAVE.

Our office requires a 24 hour notice if you are not able to make your appointment. If we do not receive this notice, a fee of $75.00 will be charged to your account.

X-ray Requirements--We pride ourselves in delivering the highest standard of care; therefore, complete diagnostic x-rays are necessary. We require a complete series of x-rays on new patients and patients who have not been to see us on a regular basis. **If you have had this series done with another dentist in the past three years, we ask that you bring them with you on your initial visit. IF YOU DO NOT HAVE THEM OR ARE NOT ABLE TO RETRIEVE THEM FROM YOUR PRIOR DENTIST BEFORE YOUR APPOINTMENT WITH US, WE WILL NEED TO TAKE X-RAYS AND BILL YOU.**

Insurance Policy—The patient is always expected to pay his/her portion at the time of service, including co-pay and deductibles. As a courtesy to all of our patients with insurance, we will file dental services with your primary insurance company, and if applicable your secondary insurance. The normal time allowed for insurance response is 30 days. Any charges remaining on your account after your insurance pays are ultimately your responsibility.

Payment Policy- Our office requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the financial department. If other arrangements are made with our finance department, the patient authorizes **CAI** DENTISTRY to make such inquiries with any credit bureau regarding financial responsibilities that are deemed necessary.

Collection Policy- If your account becomes delinquent and no financial arrangements have been made, you will be responsible for legal fees, interest charges, 33 1/3% attorney fees, and any other expenses incurred in collecting your account balance. All work must be paid in full at the time of service once your account has been satisfied with the attorney.

AUTHORIZATIONS FROM PATIENT

I authorize **CAI** DENTISTRY to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any required information to outside health practitioners and for the purpose of processing insurance claims.

I understand that my insurance policy is a contract between me and my insurance company(ies) and that I am responsible to **CAI** DENTISTRY for all fees.

I authorize and request my insurance company (if applicable) 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 billed services and that I am responsible for the remaining balance.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____ Date _____________

_______ Adult Patient _______ Parent or Guardian _______ Spouse's Signature (Power of Attorney Required)

Dr. Phil Cai

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received a copy of this office's Notice of Privacy Practices.

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Please Print Name

____

Signature_________________________________ Date__________________________________

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For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement 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:

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