NEW PATIENT REGISTRATION

FIRST NAME: _____ LAST NAME:_____ MI:_____

PREFERS TO BE CALLED:_____DATE OF BIRTH:_____

CELL PHONE #:_____ HOME PHONE #:_____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMAIL:_____

SOCIAL SECURITY #:_____

EMERGENCY CONTACT

FIRST NAME: _____ LAST NAME:_____ MI:_____

CELL PHONE #:_____ HOME PHONE #:_____

RELATIONSHIP TO PATIENT:_____

DENTAL INSURANCE

INSURANCE COMPANY:_____

POLICY ID OR SOCIAL SECURITY #:_____

INSURANCE COMPANY'S PHONE #:_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DATE OF BIRTH:_____

POLICY HOLDER'S EMPLOYER:_____

How did you hear about us? (Circle One)

GOOGLE FACEBOOK INSTAGRAM FRIEND/FAMILY OTHER:_____

MEDICAL HISTORY FORM

General Information:

Patient's Name:_____ DOB:_____

Do you wear contact lenses? ☐ Yes ☐ No

Are you currently taking diet pills? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No How frequent? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No How frequent? _____

Do you use controlled substances? ☐ Yes ☐ No

FOR WOMEN:

Are you currently taking birth control? ☐ Yes ☐ No

Are you pregnant, or do you think you may be pregnant? ☐ Yes ☐ No Due Date:_____

Are you nursing? ☐ Yes ☐ No

Medical History:

Physician's Name:_____ Phone #:_____

Date of Last Physical Exam:_____

Have you ever been hospitalized or had surgery of any kind? Please describe: _____

_____

_____

_____

Have you ever suffered a major head or neck injury? If so, please describe:_____

_____

Are you currently taking any medications? Please list, including vitamins and natural substances:

_____

_____

_____

Do you have any allergies? (Circle) *Aspirin* *Penicillin/Amoxicillin* *Latex* *Tetracycline*

Codeine *Acrylic* *Sulfa* *Metal* *Local Anesthetics* *Barbiturates*

Other: _____

Are you taking or have you ever taken any bisphosphonate (bone modifying), including Boniva, Fosamax, Actonel, Aredia, Zometa, etc.? ☐ Yes ☐ No

If yes, were these medications administered via IV or orally? _____

Have you ever had a joint replacement? ☐ Yes ☐ No

Has your physician or previous dentist ever recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Please mark (X) your response to indicate if you have had any of the following diseases/problems:

	Yes	No		Yes	No
Heart Murmur	☐	☐	Cancer/Chemotherapy/Radiation	☐	☐
Mitral Valve Prolapse	☐	☐	Chest Pain	☐	☐
Artificial Heart Valves	☐	☐	Chronic Pain	☐	☐
Rheumatic Fever	☐	☐	Diabetes	☐	☐
Cardiovascular Disease	☐	☐	Eating Disorder	☐	☐
Angina	☐	☐	Malnutrition	☐	☐
Arteriosclerosis	☐	☐	Gastrointestinal Disease	☐	☐
Congestive Heart Failure	☐	☐	Reflux/Persistent Heartburn	☐	☐
Coronary Artery Disease	☐	☐	Ulcers	☐	☐
Damaged Heart Valves	☐	☐	Thyroid Problems	☐	☐
Heart Attack	☐	☐	Stroke	☐	☐
Low Blood Pressure	☐	☐	Glaucoma	☐	☐
High Blood Pressure	☐	☐	Hepatitis, Jaundice, Liver Disease	☐	☐
Congenital Heart Defects	☐	☐	Epilepsy	☐	☐
Pacemaker	☐	☐	Fainting/Dizzy Spells	☐	☐
Rheumatic Heart Disease	☐	☐	Neurological Disorders	☐	☐
Abnormal Bleeding	☐	☐	Sleep Disorder/Sleep Apnea	☐	☐
Anemia	☐	☐	Mental Health Disorder	☐	☐
Blood Transfusion	☐	☐	Recurrent Infections	☐	☐
Hemophilia	☐	☐	Kidney Problems	☐	☐
AIDS/HIV Infection	☐	☐	Night Sweats	☐	☐
Arthritis	☐	☐	Osteoporosis	☐	☐
Autoimmune Disease	☐	☐	Persistent Swollen Glands in Neck.	☐	☐
Rheumatoid Arthritis	☐	☐	Severe Headaches/Migraines	☐	☐
Systemic Lupus Erythematosus	☐	☐	Severe or Rapid Weight Loss	☐	☐
Asthma	☐	☐	Sexually Transmitted Disease	☐	☐
Bronchitis	☐	☐	Excessive Urination	☐	☐
Emphysema	☐	☐	Snoring	☐	☐
Sinus Trouble	☐	☐	OTHER:_____		
Tuberculosis	☐	☐	_____		

If you answered yes to any of the above questions, please elaborate: _____

_____

_____

I certify that I have read and understand the above, and that the information given on this form is accurate. I understand the importance of a truthful health history, and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Guardian:_____ Date:_____

DENTAL HISTORY FORM

Patient's Name:_____ DOB:_____

Reason For This Visit: _____

Date of Last Dental Visit:_____Date of Last X-Rays: _____

Previous Dentist Name:_____ Phone:_____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Is your drinking water fluoridated?_____

Do you use a fluoridated mouthrinse?	☐ Yes	☐ No
Do your gums bleed when you brush or floss?	☐ Yes	☐ No
Are your teeth sensitive to hot or cold?	☐ Yes	☐ No
Are your teeth sensitive without any stimulus?	☐ Yes	☐ No
Do any of your teeth hurt?	☐ Yes	☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No
Have you had any head/neck or jaw injuries?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you ever had periodontal treatment (gums)?	☐ Yes	☐ No
Do you wear a complete or partial denture?	☐ Yes	☐ No
Have you ever had any difficult extractions of teeth?	☐ Yes	☐ No
Do you have frequent headaches?	☐ Yes	☐ No
Do you have clicking/popping in your jaw joint?	☐ Yes	☐ No
Do you ever have difficulty chewing?	☐ Yes	☐ No
Do you ever have difficulty in opening or closing your jaw?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Have you ever been diagnosed with sleep apnea?	☐ Yes	☐ No

Do you have any concerns about your teeth, or things you would like to change about your smile?

_____

_____

_____

General Dental Informed Consent

At Cardinal Family Dentistry, we would like for all of our patients to have full knowledge and understanding of the risks and benefits of dental procedures. Please review the procedures listed, and ask any questions that you may have. A treatment plan for all restorative work or periodontal treatment, which includes **estimated** fees and treatment specific authorization will be presented to you for your review and signature at the time the treatment is recommended.

1. **Prophylactic Cleaning:** Regular dental cleanings are imperative to maintaining optimal oral health. In the absence of periodontal disease, Dr. Barker will recommend that you return to have your teeth cleaned at regular intervals, often between 3 months and 1 year. Cleanings can cause some gum tenderness and soreness, especially in the presence of inflammation. In addition, on very rare occasions, prophylactic cleanings can cause damage to existing teeth or restorations in your mouth.
2. **X-Rays:** X-ray evaluation of your teeth is imperative for Dr. Barker to be able to perform a complete dental exam. The ADA currently recommends receiving a radiographic examination at regular intervals, the timing of which varies based on your risk of cavities. Dr. Barker will discuss with you what interval is appropriate with you, and which x-rays you may need at any given time. Please remember that it is impossible for Dr. Barker to treat what she cannot see, so should you decline x-ray evaluation, it may restrict what procedures we are able to perform on you going forward.
3. **Changes in Treatment:** During treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during initial evaluation, or the extent of the work needed is different than what was initially expected. Dr. Barker makes every effort to predict all possibilities before treatment begins, and to inform you of both best and worst case scenarios so you are aware of both the treatments that might be needed and the costs associated with those treatments. Dr. Barker will keep you informed throughout the treatment if any additional procedures are deemed necessary.
4. **Removal of Teeth:** While our goal is to maintain our natural teeth for as long as possible, on occasion Dr. Barker may recommend that you have a tooth taken out. If alternatives exist, they will be explained to you, and could include root canal therapy or periodontal therapy. On occasion, especially when infection is involved, removing the teeth does not completely heal the infection and it may be necessary to have antibiotic therapy or other further treatment. Complications do occasionally arise during or after surgery, and can include but are not limited to pain, swelling, spread of infection, dry socket, loss of feeling in the teeth, lips, tongue, and surrounding tissue that can be either temporary or permanent, or a fractured jaw. It is your responsibility to follow up with Dr. Barker should any post-operative concerns occur, and to seek prompt medical attention. Any further treatment required by a specialist, or in very rare cases, hospitalization, would be your responsibility.
5. **Crowns and Bridges:** When we prepare your tooth to receive a crown, Dr. Barker will place a temporary crown on your tooth to seal the area while your final crown is being made by the dental lab experts! These temporary crowns are cemented with temporary cement, and on occasion do fall off. As such, we recommend eating only soft foods on the side where your temporary crown is cemented. It is your responsibility to notify Dr. Barker ASAP if your temporary comes off so that she may recement it for you. If you cannot find your temporary crown, and think that you may have swallowed it, Dr. Barker may recommend a chest x-ray to ensure that the crown has not actually landed in your lungs. With regards to your final crown, do remember that we match shade as well as we can, and any concerns or changes to the shade of your crown need to be communicated to the staff as soon as possible. You will be asked to make a final approval the shade at the preparation

appointment, after which no changes can be made. Lastly, please remember that on occasion, teeth that require crowns may require further treatment including, but not limited to root canal therapy or clinical crown lengthening.. Dr. Barker will review all of these risks with you before beginning your crown appointment.

6. **Removable Partial Dentures:** Removable partial dentures are acrylic, metal, and/or porcelain replacements for some of your natural teeth that have gone missing. There is a risk that they will become loose or ill fitting over time, or even break. Often times, your partial will require a "reline" at regular intervals to ensure it is well adapted to your mouth and isn't rocking or creating sore spots. Please remember that these relines are not included in the initial partial denture fee, and will only be assessed as needed.
7. **Endodontic Treatment (Root Canal):** There is no guarantee that root canal treatment will save a tooth or relieve symptoms. Complications may arise, and will be explained to you before your treatment is begun, but can include missed canals or perforation of the tooth root.
8. **Periodontal Treatment:** Limited periodontal treatments can be performed in our office at Cardinal Family Dentistry, including scaling and root planing (deep cleaning). Should more extensive treatment be required to treat severe bone loss, recession, or mobility, Dr. Barker will refer you to a periodontist with whom we will work in conjunction to manage your case. You may be required to see the periodontist regularly, even for "cleanings", be referred back to our office, or be asked to alternate cleanings at each office so both doctors can continue monitoring your condition. Should active periodontal disease exist, please remember that Dr. Barker cannot provide a "regular cleaning", as it will not be adequate treatment for the problem and will likely leave tartar that can cause inflammation and infection around your teeth.
9. **Implants:** Depending on your particular case, Dr. Barker may or may not be able to place your dental implant in our office. If the complexity of the case is deemed too much, or your health is particularly compromised, Dr. Barker may refer you to an oral surgeon or periodontist for placement of your dental implant, after which you will return to our office to have the final "crown" placed on your implant. Dental implant treatment requires several months, whether it is done by Dr. Barker or at another office, and it's important to have patience to give your implant the best chance of succeeding.
10. **Sealants:** Sealants are placed on teeth with pits or grooves that are at elevated risk for developing cavities. They are not guaranteed to prevent cavities, and on occasion need to be added to or replaced completely as they can chip over time. Should your sealants fall out less than 2 years after they were placed, we will replace them for you at no charge. Sealants can be done on patients of any age, and are beneficial for both children and adults. Dr. Barker will discuss any questions you have regarding sealants should that be a proposed treatment option for you.
11. **Fillings:** Fillings are meant to replace chips, cracks, or decay in natural teeth. Post-operative sensitivity is common after a filling and often goes away, but if it is lingering or severe, it is your responsibility to follow up with Dr. Barker as soon as possible. On occasion, further treatment is required after a filling including possible root canal treatment or extraction should the filling not resolve the problem or symptoms. Fillings can develop cavities underneath them, and can also crack, chip, or fall out. The lifespan of a filling is prolonged with daily oral care including but not limited to regular brushing and flossing. Should you have any concerns about how your filling feels after leaving our office, please let us know as soon as possible.

I attest that I have carefully read the above informed consent, and fully understand all risks as they relate to my case.

Patient Name:_____ Date:_____

Patient or Guardian Signature:_____

Practice Policies

Thank you so much for choosing Dr. Barker and Cardinal Family Dentistry for your dental care. We are thrilled that you have chosen us as your dental provider, and appreciate the opportunity to provide you with exceptional care. We feel that the best relationships begin with the sharing of expectations, and we welcome your questions regarding the below policies.

Appointment Policy

When you request an appointment, we reserve that time especially for you and your provider so that we may be dedicated to your care. We understand that your time is valuable, so we make every attempt to see you on time, and need for you to do the same. The below policies are in place so that we can best serve all of our patients.

Late Arrival: We make every attempt to be on time with our schedule, and we hope you will do the same! In order to allow us to provide excellent, timely care to our other patients, if you are more than 15 minutes late, we may be unable to provide treatment that day, or may only be able to provide a portion of planned treatment. If you are late for two appointments, you will be charged a broken appointment fee of $25 per hour scheduled, and all future appointments, including those for regular cleanings, must be paid for in advance.

Change of Appointment: In the event that you need to change an appointment, please provide our office with at least a 48-hour notice to avoid a broken appointment charge of $25 per hour scheduled. This fee must be paid before your appointment may be rescheduled. If you cancel/change without proper notice, the broken appointment charge must be paid before rescheduling, and all future appointments, including those for regular cleanings, must be paid for in advance.

Missed Appointment: If you fail to appear for an appointment, your account will be charged $25 per hour scheduled – that fee must be paid if you wish to reschedule.

Financial Policy

We look forward to providing you with excellent care, and convenient financial arrangements. Our financial arrangements may vary based on recommended treatment plans, respective fees, and patient's financial capabilities. Please read below to ensure that you understand our office polices:

1. For **recall cleaning and periodontal maintenance appointments**, as well as **emergencies**, payment is due in full **at the time services are rendered**.

2. For **restorative procedures** including, but not limited to fillings, crowns, implants, and extractions, payment is due in full **at the time the appointment is scheduled**.

Insurance: We will make every effort to help you maximize your dental benefits! We would however like you to know that insurance policies vary greatly, as do the terms of their contracts, so the coverage amounts that you are provided in your treatment plan are only ESTIMATES, not guaranteed coverage.

- If we are in network with your insurance company, your estimated patient portion is due at the time of service or scheduling, depending on your appointment type. We will bill your insurance for you, and allow 60 days for payment to be rendered. Should payment not be received within 90 days, you will be responsible for the entire balance, and it will be due in full at that time.
- If we are out of network with your insurance company, payment will be due for the entire service, in full, and insurance will reimburse you directly for any covered services.

Payment Plans: In select cases, we do offer in house payment plans, and cater these to the particular patient's treatment plan and financial capabilities. Please let us know if you have concerns about paying for your treatment and we will be happy to discuss options with you

Minors: Payment for services provided to any minors is the responsibility of the accompanying adult.

Service Charges: For any past due accounts over 90 days where no payment arrangements have been previously made with our office, a 5% monthly interest charge will be applied. A $40 dollar fee will be assessed for any returned checks.

Collection Fees: Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent: The patient (account holder) agrees to be fully responsible for total payment of treatment performed in the office

Credit Reports: We may request information from you and make whatever inquiries we consider necessary and appropriate (including requiring a consumer report from consumer reporting agencies) in considering your application for an account, and for the purposes of any updates, renewals, or extensions of charging privileges, or reviewing or collecting your account. In addition, we may report information about your account to credit bureaus. Late payments, missed payments, or other defaults on your account may be reflected in your credit report. If you believe that we have information about you that is inaccurate or that we have reported or may report to a credit reporting agency information about you that is inaccurate, please notify us of the specific information that you believe is inaccurate by writing to us at the address above.

No Waiver by Us: We may waive our right to charge a fee to your account without waiving any other right we have under this financial policy, including our right to charge that same fee at any other time.

Billing Questions: If you have a question about your statement, please feel free to contact our office. You will be directed to a dedicated financial coordinator that will be happy to assist you with your questions.

Should you have any questions, please let one of our staff members know.

Patient Name (Print): _____ Date:_____

Patient or Responsible Party Signature: _____

Cardinal Family Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

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

Name (Print): _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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

_____