

CAMBRIDGE FAMILY DENTAL

Juan Manuel Molina, D.D.S.

Welcome To Our Office!

PLEASE COMPLETE THE FRONT AND BACK PAGES.

Thank you for choosing Cambridge Family Dental as your dental provider. We are committed to providing you the best possible dental care.

If you have any problems or questions while completing the form below, we will be happy to help.

Patient Name _____ Goes by _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Home Phone () _____ Cell Phone () _____

Full Time Student? Yes No School Attending _____ Social Security # _____ - _____ - _____

Marital Status Single Married Separated/Divorced Widow Sex Male Female

Purpose of today's visit _____ How did you hear of our office? _____

List other family members seen by us: _____

Person Responsible for Account

Name _____ Employer _____ Position _____

Address _____ Work Phone () _____

City/State/Zip _____ Soc. Sec. # _____ - _____ - _____

Phone () _____ State DL # _____ Date of Birth _____

Relationship to Patient

Self Father Mother Spouse Other _____

Today's visit will be paid by Cash Check Credit Card Insurance Assignment

Primary DENTAL Insurance

Ins. Co. Name _____ Ins. Address _____

Ins. Phone () _____ Group Plan # _____

Effective Date _____ Insured Name _____

Address _____ Date of Birth _____

Social Security # _____ - _____ - _____ Employer _____

Physician's Name _____ Physician's telephone # () _____ Last Visit _____

Emergency Information: Please List the names and telephone numbers of a relative (or friend) *not living with you* that we may be called in a case of an emergency.

Name _____ Relation _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

RELEASE: I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. PHOTOS MAY BE TAKEN FOR INSURANCE PURPOSES OR USED AS A TOOL TO HELP EDUCATE PATIENTS. I AM RESPONSIBLE TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH HISTORY.

Signature _____ Date _____

Dentist's Signature _____ Date _____

Dentist's Initials _____ Date _____ / Dentist's Initials _____ Date _____

WOMEN: ARE YOU PREGNANT? Yes No. If yes, what Trimester (or weeks) _____ Name of OB/GYN _____

Are you taking Birth Control Pills or Hormone Medication? Yes No.

*** PLEASE FILL THE MEDICAL QUESTIONS ON THE BACK ***

Mark Yes No For Each Condition

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Pace Maker | <u>Allergies</u> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Anesthetic |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Erythromycin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No Jewelry |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Metals |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Sulfa |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis B | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Tetracyclin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Defect | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No Topical Anesthetic |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cosmetic surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV / AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No -Other |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Yellow Jaundice | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No Lupus | | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse | | |

- Are you presently taking **ANY** drugs or medications? Yes No If yes, please list _____
- Are you presently under the care of a physician? Yes No If yes, for what? _____
- Do you take any herbal supplements or vitamins? Yes No If yes, name them _____
- Do you have **ANY** disease or condition not listed or anything about your health problem that we have not covered? Yes No
If yes, please list _____
- Have you ever experienced any complications or illness following dental treatment? Yes No If yes, explain _____
- Do you have a history of fainting? Yes No If yes, explain _____
- Do you use tobacco? Yes No If yes, what type and how many times a day and for how many years. _____
- Date of last dental exam _____ Were x-rays taken? Yes No
- Were your Teeth Cleaned? Yes No
- Have you ever been treated for gum disease? Yes No If yes, what year? _____
- Do you clench or grind your teeth? Yes No If yes, do your parents grind their teeth _____
- Does your jaw click or pop? Yes No If yes, does it hurt? _____
- Do you experience frequent pain or soreness in the muscles of your face or around your ear? Yes No

We ask that all patients read our Financial Policy. **Payment for services is due at the time services are rendered.** We accept cash, check, credit cards and approved financing. We understand that temporary financial problems may affect payment for your treatment. We encourage you to communicate any such problems to us, so we may assist you in management of your account. However, balances older than 60 days may be subject to collection placement and additional fees. Return check fee is \$30.00.

We may accept assignment of insurance benefits. However, you must understand that:

- The employees of Cambridge Family Dental are NOT representatives of your insurance company. We cannot guarantee payment from your insurance company. We can only estimate your benefit coverage based on the information given to us by your insurance company.**
- Your insurance policy is a contract between you, your employer and the insurance company. We are **NOT** a party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.
- Not all services are covered by insurance companies. All charges are your responsibility whether your insurance company pays or does not pay. **Deductibles and co-payments are due at the time of treatment.**
- If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After 45 days, we may require you to pay the amount due by your insurance company.
- I authorize payment from my insurance carrier be made directly to the dentist. I authorize this office to release necessary medical or dental information about me to my insurance carrier.

Fixed or removable prosthetics, such as dentures, crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services, is, therefore, considered to be due and payable when the initial impression is made. As a courtesy to you, we will, if necessary, accept 50% of this amount at the time of impression. The balance must be paid at the time of permanent seating. **PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE COMFORT AND PROPER FIT.** You will be charged an additional fee, if you fail to have your prosthetics permanently seated within 60 days from date of impression, and second impression must be done.

ALL X-RAYS TAKEN ARE PART OF OUR PERMANENT RECORDS. YOU MAY REQUEST COPIES OF X-RAYS OR RECORDS; HOWEVER, A DUPLICATION FEE WILL APPLY. Any photos taken are the property of Dr. Molina.

Again, thank you for choosing Cambridge Family Dental as your dental care provider. We appreciate your trust in us and the opportunity to serve you.

Sign and date: _____

