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.
PLEASE PRINT CLEARLY

Patient Name_____ Date of Birth _____ Age _____

Goes by (nick name) _____ Social Security # _____ - _____ - _____

Address_____ Home Phone ( ) _____

Apt. # _____City _____ Cell Phone ( ) _____

State_____ Zip Code_____ E-Mail Address _____

Full Time Student? ☐ Yes ☐ No School Attending _____

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
Name of Pharmacy you use and telephone number: _____

DENTAL Insurance

Suscriber's Name _____Date of Birth_____Identification number#_____
Suscriber's Address _____Phone Number (_____) _____
Employer _____Insurance Plan Name_____Phone number_____
Insurance Address _____
Group Plan # _____Effective Date _____

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.

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.

Signature_____ Date _____

Dentist's Signature _____ Date _____

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

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

WOMEN: ARE YOU PREGNANT? ☐ Yes ☐ No. If yes, what Trimester (or weeks) _____ Name of OB/GYN_____
Contact Number #_____ Are you taking Birth Control Pills or Hormone Medication? ☐ Yes ☐ No.

Mark ☐ Yes ☐ No For Each Condition

☐Yes ☐No Abnormal bleeding
☐Yes ☐No Alcohol abuse
☐Yes ☐No Allergies
☐Yes ☐No Anemia
☐Yes ☐No Angina
☐Yes ☐No Arthritis
☐Yes ☐No Artificial Heart Valve
☐Yes ☐No Artificial Joint (knee, hip or shoulder, Heart Valve etc)
☐Yes ☐No Asthma
☐Yes ☐No Autoimmune Disease
☐Yes ☐No Blood Transfusion
☐Yes ☐No Cancer Chemotherapy
☐Yes ☐No Colitis
☐Yes ☐No Congenital Heart Defect
☐Yes ☐No Covid-19
☐Yes ☐No Diabetes
☐Yes ☐No Difficulty breathing
☐Yes ☐No Drug Abuse
☐Yes ☐No Emphysema
☐Yes ☐No Epilepsy
☐Yes ☐No Fainting spells
☐Yes ☐No Fever Blisters
☐Yes ☐No Frequent headaches
☐Yes ☐No Glaucoma
☐Yes ☐No Heart Attack
☐Yes ☐No Heart Murmur
☐Yes ☐No Heart Surgery
☐Yes ☐No Hemophilia
☐Yes ☐No Hepatitis A, B, C
☐Yes ☐No High Blood Pressure
☐Yes ☐No HIV / AIDS
☐Yes ☐No Kidney Problems
☐Yes ☐No Liver Disease
☐Yes ☐No Low Blood Pressure
☐Yes ☐No Lupus
☐Yes ☐No Mitral Valve Prolapse
☐Yes ☐No Pace Maker/Defib.
☐Yes ☐No Psychiatric Problems
☐Yes ☐No Radiation Therapy
☐Yes ☐No Rheumatic Fever
☐Yes ☐No Seizures
☐Yes ☐No Shingles
☐Yes ☐No Sickle Cell Disease
☐Yes ☐No Sinus Problems
☐Yes ☐No Stroke
☐Yes ☐No Thyroid Problems
☐Yes ☐No Tuberculosis
☐Yes ☐No Ulcers
☐Yes ☐No Venereal Disease
☐Yes ☐No Yellow Jaundice

Allergies

☐Yes ☐No Aspirin
☐Yes ☐No Codeine
☐Yes ☐No Dental Anesthetic
☐Yes ☐No Erythromycin
☐Yes ☐No Jewelry
☐Yes ☐No Latex
☐Yes ☐No Metals
☐Yes ☐No Penicillin
☐Yes ☐No Sulfa
☐Yes ☐No Tetracycline
☐Yes ☐No Topical Anesthetic
☐Yes ☐No –Other
_____

1. Are you presently taking **ANY** drugs or medications? ☐ Yes ☐ No If yes, please list _____
_____
2. Are you presently under the care of a physician? ☐ Yes ☐ No If yes, for what? _____
3. Do you take any herbal supplements or vitamins? ☐ Yes ☐ No If yes, name them _____
4. 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 _____
5. Have you ever experienced any complications or illness following dental treatment? ☐ Yes ☐ No If yes, explain _____
6. Do you have a history of fainting? ☐ Yes ☐ No If yes, explain _____
7. Do you use tobacco? ☐ Yes ☐ No If yes, what type and how many times a day and for how many years. _____
8. Date of last dental exam _____ Were x-rays taken? ☐ Yes ☐ No
9. Were your Teeth Cleaned? ☐ Yes ☐ No
10. Have you ever been treated for gum disease? ☐ Yes ☐ No If yes, what year? _____
11. Do you clench or grind your teeth? ☐ Yes ☐ No If yes, do your parents grind their teeth _____
12. Does your jaw click or pop? ☐ Yes ☐ No If yes, does it hurt? _____
13. 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:

1. **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.**
2. 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.
3. 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.**
4. 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.
5. 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.
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.
Signature: _____ and date _____ 9.12.2023 **(Web Page New Patient forms.doc)**