Welcome to CITIDental

Date: ________________

Patient Information:

Name__________________________________ D.O.B.____________ SS#_________________

Address____ Apt_________________

Town__________________________________ State_________ Zip___________ Marital Status______

Home Phone_______________________Cell________________________ Other_________________

Email_____________________________________

Employer__________________________________ Work Phone____________________________

EMERGENCY CONTACT: Name_____________________________Phone____________________

Responsible Party: (if different from above)
Name______________________________________ Address____________________________________
SS#_______________________________________ Birth date____________________________________

Whom May we thank for this referral? (current patient, Yellow Pages, website, etc)
____

Dental Insurance Information: check if does not apply ____

Name of person carrying insurance____

Insurance Company Name____

Insurance ID # **or** social security #____

Insured's D.O.B_________________________________

Group Number_________________________________

Insured employer name____

Do you have another dental insurance?____

Dental History:

How can we help you today?____

Former Dentist's Name:__________________________________ Date of last dental visit?________________

How often do you brush?______________________________ How often do you floss?___________________

PLEASE CHECK ALL THAT APPLY:

Y or N	Bad Breath	Y or N	Food Collects between teeth	Y or N	Pain around ear
Y or N	Bleeding Gums	Y or N	Foreign Objects	Y or N	Periodontal Treatment
Y or N	Blisters on lips/mouth	Y or N	Grinding teeth	Y or N	Sensitivity to cold
Y or N	Burning on Tongue	Y or N	Gums swollen or tender	Y or N	Sensitivity to hot
Y or N	Chew on one side of mouth	Y or N	Jaw pain or tiredness	Y or N	Sensitivity to sweets
Y or N	Cigarette or cigar smoking	Y or N	Lip or cheek biting	Y or N	Sensitivity when biting
Y or N	Clicking or popping jaw	Y or N	Loose teeth/broken fillings	Y or N	Sores in mouth
Y or N	Dry mouth	Y or N	Mouth breathing	Y or N	Orthodontic Treatment
Y or N	Fingernail biting	Y or N	Mouth pain		

Patient Name______________________________________ **Date**______________

Please answer the following questions:

1. Have you ever taken pre-medication (antibiotics) before dental visits? Y or N
2. Have you had any periodontal treatment (gum treatment) in the past? Y or N
3. Do you have sensitivity to hot, cold, sweets or when chewing? Y or N
4. Do you take Aspirin (Bayer, Bufferin) on a regular basis? Y or N
5. Have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel)? Y or N
6. Have you ever been diagnosed with a problem with either jaw joint? Y or N
7. Does your jaw click, pop, or make noise when you open and close? Y or N
8. Is there pain or tenderness in your jaw joint when you open, close or chew? Y or N
9. Has your jaw ever locked open or closed? Y or N
10. Do you have frequent headaches? If so how often? _________________ Y or N
11. Do you clench or grind your teeth, or ever been told you do? Y or N
12. Have you ever had trauma to your chin or jaw? Y or N

Medical History:

Physician's Name________________________________ Date last visit? (approx) ______________

Additional Specialist doctors:_______________________ Date of last visit?______________

Please circle Y (yes) or N (no) for ALL medical conditions listed below:

Y or N	Aids/HIV	Y or N	Jaundice	Y or N	Blood Disease
Y or N	Cortisone Treatments	Y or N	Sinus Trouble	Y or N	Glaucoma
Y or N	Heart Problems	Y or N	Artificial pins, joints	Y or N	Mitral Valve Prolapse
Y or N	Respiratory Disease	Y or N	Diabetes	Y or N	Thyroid Problems
Y or N	Anemia	Y or N	Kidney Disease	Y or N	Cancer
Y or N	Circulatory Problems	Y or N	Stroke	Y or N	Headaches
Y or N	Hepatitis (type____)	Y or N	Asthma	Y or N	Pacemaker
Y or N	Rheumatic Fever	Y or N	Epilepsy	Y or N	Tumors or growths
Y or N	Arthritis	Y or N	Liver Disease	Y or N	Chemical Dependency
Y or N	Congenital Heart Lesions	Y or N	Skin Rash	Y or N	Heart Murmur
Y or N	High Blood Pressure	Y or N	Abnormal Bleeding	Y or N	Radiation treatment
Y or N	Scarlet Fever	Y or N	Fainting/dizziness	Y or N	Ulcers
Y or N	Artificial Heart Valves	Y or N	Low Blood Pressure	Y or N	Venereal Disease
Y or N	Persistent cough	Y or N	Swollen neck glands	Y or N	Weight Loss, unexplained

Women: Are you Pregnant ____ Nursing ____ Taking Birth Control Pills? ______

Have you ever taken any group of drugs that are affiliated with Fen-phen? Yes or No

Please List **ALL** medications you are taking, the amount and frequency for each: _________________________

__________________________________ ____

__________________________________ ____

__________________________________ ____

Allergies: Do you have any allergy to any of the following OR medication? Please circle any that apply

Latex	Aspirin	Barbituates (sleeping pills)
Penicillin	Codeine	Iodine
Sulfa	Local Anesthetic	Other____________________

SIGNATURES: Please sign below:

PATIENT or guardian ___________________ ____/____/____ DOCTOR/R.D.H_____________ ___/___/___

Attention Insured Patient,

In order to submit claims accurately, the following are needed:

1. **We need all necessary information on the policy holder**.

2. **Information does need to be verified by the insurance company.**

Note:

Information provided by the insurance company **IS NOT A GUARANTEE OF BENEFITS**, only *estimation*. Please review your policy book so there are no misunderstandings. If you do not have a policy book, contact your human resource office.

You, the patient, are responsible for your own policy, we are third party billing only, and given minimal information by your insurance company.

You are responsible for all co-pays at time of service, and any balance that may occur after the insurance has paid. We do send dental pretreatment estimates to your insurance if treatment is diagnosed and discussed. This is done to have approval on file if treatment is rendered. It is **NOT** submitted for reimbursement until actual services are performed.

OUR GOAL:

To give you the best estimate possible with the information given to us by your insurance company. **Until the insurance company receives the actual CLAIM, it remains an ESTIMATE and not a GUARANTEE**. TREATMENT PLANS AVAILABLE.

By signing below,

I authorize direct payment of the insurance benefits to CITI**Dental** and its' associate doctors, for treatment rendered to me and/or my child/children.

I have read and understand the above policies.

Patient/parent/guardian______________________________________Date_________

Office Policies Of CITI**Dental**

FINANCIAL AGREEMENT: ***Payment is due at time of service***

Financial assistance is available, upon credit approval.

As a courtesy to you, we will submit all charges to the insurance company. Insurance is designated to cover a portion of the customary fee. Co-payments are collected at time of visit. (Please see our insurance policies.)

BALANCES LEFT ON ACCOUNT FOR OVER 60 DAYS: All parties will be responsible for the cost of collection, which may include but is not limited to any and all collection and legal fees.

Returned checks: There will be a $25.00 fee. **Initial_________**

CANCELLATION AND FAILURE TO ARRIVE:

We understand that circumstances do arise that can keep you from a dental appointment. Please, have the courtesy to give the office 48 hours notice. Please understand that we have reserved the doctors time for you and we will try to contact you at all phone numbers listed to confirm your appointment.

There will be a $75.00 charge for all appointments missed or cancelled without 48 hours notice

Initial_________

X-RAYS: Original x-rays are the property of CITI**Dental**. If you wish to have your x-rays duplicated, there will be a $25.00 charge. A notice of 72 hours is required prior to picking up or mailing out.

Initial_________

PRIVACY NOTICE:

Privacy Act: I give CitiDental permission to send reminder postcards to me through U.S. Postal Service, and to leave messages via answering machine, voicemail, e-mail, cell phone, or other family members.

By signing below, I understand the above listed policies, and assume responsibility for all services rendered.

Patient/Parent/Guardian_______________________________________Date_____________

CitiDental

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.

____
Please print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. Acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specifiy)

____

____