Email Form

Print Form

Cedar Hills Family Dentistry
D. MICHAEL SUTTON, DDS

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle or check one) ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F	
Street address:		City:	State/ZIP code			
SSN:	Cell Phone:		Home Phone:			
Primary contact for appointment confirmations:			Phone Number:			
Previous Dentist:			Phone Number:			
Occupation:	Employer:		Employer Phone:			
Chose clinic because/Referred to clinic by (please check one box):	❑ AD	❑ Insurance Plan	❑ Google			
❑ Close to home/work	❑ Facebook	❑ Our website	❑ Yellow Pages	❑ Other:		
❑ Friend/Family member/ Employee Name:			Email address:			

INSURANCE INFORMATION

*Please give your insurance card to the receptionist. All fields marked with an * must be completed for our office to submit insurance claims on your behalf.*

*Subscriber's Name:	*Birth date:	Address (if different from your own):	
*Subscriber's Employer:	Employer phone:	*Group Number:	Effective date:
*Insurance Company:		*Insurance Phone number:	
*Policy Number:	*SSN:	*Patient relation to subscriber:	

Secondary insurance? ❑ Yes ❑ No (If no, proceed to HIPPA: Notice of Privacy Practices)

*Secondary Subscriber:	*Birth date:	*Policy number:	*SSN:
*Subscriber's Employer:	Employer phone:	*Group Number:	*Effective date:
*Insurance Company:	*Insurance Phone:	*Patient relation to subscriber:	

HIPPA: NOTICE OF PRIVACY POLICY

I have been given a copy of the HIPAA Privacy Policy.

→ ***Patient/Guardian Signature*** ***Date***

RESPONSIBLE PARTY INFORMATION

Person responsible for bill:	Relation to patient:	Birth date:	Is this person a patient at our office? ❑ Yes ■ No
Address (if different from your own):		Phone number (if different from your own):	

CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon, diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I understand I can ask for a complete recital of any possible risk of complications.

→ ***Patient/Guardian signature*** ***Date***

EMERGENCY CONTACT INFORMATION

Name of local friend or relative:	Relation to patient:	Daytime phone number:

The above information is true to the best of my knowledge. I understand that it is my responsibility to inform this office promptly if there are any changes to my personal information or health status.

Patient/Guardian Signature DATE

CEDAR HILLS FAMILY

Medical and Dental History

Patient name (please print):_____ Birth Date: _____ Date Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Dental History

Do you have, or have you ever had any of the following:

- ☐ Dentures
- ☐ Braces
- ☐ Partial Dentures
- ☐ Periodontal (gum) treatments

How long has it been since your last cleaning?

- ☐ 1-2 years
- ☐ 3-5 years
- ☐ 5+ years
- ☐ Less than 1 year

On a scale of 1 to 10, with 10 being the highest:

How important is dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Smile Survey (Please check any of the following that apply to you)

Sensitivity (hot, cold, sweets, pressure)	☐ Yes	☐ No	If yes	
Discomfort when chewing	☐ Yes	☐ No	If yes	
Headache, earache, neck pain	☐ Yes	☐ No	If yes	
Jaw joint pain	☐ Yes	☐ No	If yes	
Teeth or fillings breaking	☐ Yes	☐ No	If yes	
Bad breath/bad taste in mouth	☐ Yes	☐ No	If yes	
Bleeding, swollen, irritated gums	☐ Yes	☐ No	If yes	
Grinding or clenching teeth	☐ Yes	☐ No	If yes	
Uncomfortable showing teeth when smiling	☐ Yes	☐ No	If yes	
Unhappy with appearance or alignment of teeth	☐ Yes	☐ No	If yes	
Anxious or fearful of dental treatment	☐ Yes	☐ No	If yes	
Are Finances holding you back from the perfect smile?	☐ Yes	☐ No	If yes	
Are you interested in improving the appearance of your teeth?	☐ Yes	☐ No	If yes	
Have you been under the care of a medical doctor during the past 2 years?	☐ Yes	☐ No	If yes	
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes	
Any changes in your health since the last time you were in our office?	☐ Yes	☐ No	If yes	
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes	
Are you taking any medications, pills, or drugs? Please list.	☐ Yes	☐ No	If yes	
Do you take premedication?	☐ Yes	☐ No	If yes	

Describe any current medial treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (i.e. Botox, Collagen injections):

_____

Do you use tobacco? Chew? Smoke? Vape? ☐ Yes ☐ No

How often: _____ How long: _____

Do you use controlled substances? ☐ Yes ☐ No If yes _____

CEDAR HILLS FAMILY

Medical and Dental History (part 2)

Women: Are you…

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Latex ☐ Acrylic
☐ Metal ☐ Codeine ☐ Local Anesthetics
☐ Penicillin ☐ Sulfa Drugs

☐ Other? If Yes _____

Do you have or have you ever had?

- Aids/HIV Positive———— ☐Yes ☐No
- Alzheimer's Disease———— ☐Yes ☐No
- Anaphylaxis———— ☐Yes ☐No
- Anemia———— ☐Yes ☐No
- Angina———— ☐Yes ☐No
- Arthritis/Gout———— ☐Yes ☐No
- Artificial heart valve———— ☐Yes ☐No
- Artificial Joint———— ☐Yes ☐No
- Asthma———— ☐Yes ☐No
- Autism———— ☐Yes ☐No
- Autoimmune Disorder -———— ☐Yes ☐No
- Blood disease———— ☐Yes ☐No
- Cancer———— ☐Yes ☐No
- Chemotherapy———— ☐Yes ☐No
- Chronic Cough———— ☐Yes ☐No
- Chest Pain———— ☐Yes ☐No
- Cold sores/fever blisters———— ☐Yes ☐No
- Congenital heart disease———— ☐Yes ☐No
- Cortisone medication———— ☐Yes ☐No
- Diabetes ———— ☐Yes ☐No
- Drug addiction———— ☐Yes ☐No
- Emphysema———— ☐Yes ☐No
- Epilepsy or seizures———— ☐Yes ☐No
- Excessive Bleeding———— ☐Yes ☐No
- Fainting or dizzy spells———— ☐Yes ☐No
- Frequent Diarrhea———— ☐Yes ☐No
- Frequent Headaches———— ☐Yes ☐No
- Genital Herpes———— ☐Yes ☐No
- Glaucoma———— ☐Yes ☐No
- Gluten Allergy———— ☐Yes ☐No
- Hay Fever———— ☐Yes ☐No
- Heart Attack/Failure———— ☐Yes ☐No
- Heart Murmur———— ☐Yes ☐No
- Heart Pacemaker———— ☐Yes ☐No
- Heart Trouble/Disease———— ☐Yes ☐No
- Hemophilia———— ☐Yes ☐No
- Hepatitis A———— ☐Yes ☐No
- Hepatitis B or C———— ☐Yes ☐No
- High blood pressure———— ☐Yes ☐No
- High cholesterol———— ☐Yes ☐No
- Hives or Rash———— ☐Yes ☐No
- Hormone deficiency———— ☐Yes ☐No
- Hypoglycemia———— ☐Yes ☐No
- Kidney problems———— ☐Yes ☐No
- Leukemia———— ☐Yes ☐No
- Liver Disease———— ☐Yes ☐No
- Low Blood Pressure———— ☐Yes ☐No
- Lung Disease———— ☐Yes ☐No
- Mitral Valve Prolapse ———— ☐Yes ☐No
- Pain in Jaw Joints———— ☐Yes ☐No
- Psychiatric Care———— ☐Yes ☐No
- HPV/STI/STD———— ☐Yes ☐No
- Radiation Treatments———— ☐Yes ☐No
- Recent Weight Loss———— ☐Yes ☐No
- Renal Dialysis———— ☐Yes ☐No
- Rheumatic fever———— ☐Yes ☐No
- Rheumatism———— ☐Yes ☐No
- Scarlet Fever———— ☐Yes ☐No
- Shingles———— ☐Yes ☐No
- Sickle Cell Disease———— ☐Yes ☐No
- Sinus trouble———— ☐Yes ☐No
- Stomach/Intestinal Disease———— ☐Yes ☐No
- Stroke———— ☐Yes ☐No
- Swelling of Limbs———— ☐Yes ☐No
- Thyroid Disease———— ☐Yes ☐No
- Tonsilitis———— ☐Yes ☐No
- Tuberculosis (T.B.) ———— ☐Yes ☐No
- Tumors or Growths———— ☐Yes ☐No
- Ulcers———— ☐Yes ☐No

Have you had any serious illness not listed above? ☐Yes ☐No If Yes _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian signature: _____ Date:_____

Doctor signature:_____ Date:_____

Email Form

Print Form

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable, and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered. **We do offer a 90 day payment plan option, or a care credit option. Please ask our treatment plan coordinator about those options if you have any questions or concerns.**

If you are unable to keep an appointment, please call at least 24 hours prior to that appointment. A late cancellation fee of $25 will be charged for appointments canceled within 24 hours.

Patients who carry dental insurance understand that all dental services finished are charged directly to the patient and that he or she, not the insurance company, is personally responsible for payment of all dental services. Your insurance policy is a pre-determined arrangement between your employer and the insurance company. We are not a party to that contract. This office will help prepare and submit the insurance forms for our patients and assist in making collections from insurance companies and will credit any such collections received to the patient's account. Any co-pay quoted from this office is an estimate only, not a guarantee of coverage. Unfortunately, insurance benefits will almost always be less than anticipated. **It is your responsibility to contact your insurance to determine your particular benefits or requirements. This dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.**

A service charge of 2% per month (24% per annum) and a $3.00 billing fee on the unpaid balance will be assessed on all accounts exceeding ninety days from the date of service unless previously written financial arrangements are satisfied. After 90 days of no payment the account will be turned over to a third-party collection agency. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for, the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs, including court costs and reasonable attorney fees. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, an interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Signature of Patient, parent or guardian | Date | Witness