CDIDentalGroup
EMBRACE YOUR SMILE

Patient Name: _____ **Referred by:** _____

Phone: _____ **Date of Birth:** _____ **SSN:** _____

Address: _____ **City:** _____ **Sate:** _____ **Zip:** _____

E-Mail: _____

Our Goal

Our goal is to offer you exceptional service in a relaxing and modern facility. Providing you dental care with the objective of augmenting and sustaining overall good health is our number one priority.

The following important guidelines of our facility allow us to focus efforts and expertise toward our goal by offering you the best in dentistry. Our highly trained staff is prepared to make your visit a very positive and caring experience. Please, do not hesitate to ask us any questions that you may have pertaining to our service.

Thank you for your confidence in us. We look forward to serving you.

Concierge Service

To ensure efficient and professional care for our patients, we operate on a system of schedule appointments. We value time and understand that life can be busy, so we provide our patients with full "concierge service" which includes a prompt response time for all questions, concerns or appointment scheduling. Please call **(562)317-5258** or e-mail contactus@cdidentalgroup.com and our team will be happy to assist you with scheduling. We do encourage you to set your appointment in advance, so that the time that best suits your needs can be reserved. You can also visit our website at cdidentalgroup.com or our Facebook page. We will always do our best to respond quickly to you.

Appointment Cancellations and Deposit Policy

At all times we have a listing of patients who are requesting specific time slots. In order to accommodate our entire family of patients scheduling requests to the best of our ability, we ask you to honor our 48 hours rescheduling policy.

We strive to render excellent dental care to you and rest of our patients. In an attempt to be consistent, we have an Appointment Cancellation and Deposit Policy that allows us to schedule appointments of all the patients.

When an appointment is scheduled, that time has been set aside specially for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as fallows:

- When require that you give our office a 48-hour notice in the event that you need to reschedule your appointment. This allows for other patients to be contacted and scheduled into that appointment.
- If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee will be charged to you; this fee cannot be billed to your dental insurance company and will be your direct responsibility.
- Patients will also be required to submit a deposit of $100 which will be used towards your dental treatment to confirm your appointment. If the appointment is missed or cancelled within less than 48hours, the patient will forfeit the deposit.
- A grace period of 10 minutes will be allotted to all patients, if a patient is late more than 15 minutes to their appointment, they will be charged a missed appointment fee and will be rescheduled.

If you have any questions regarding this policy, please let our know and we will be glad to clarify any questions you may have.

Multiple missed appointments or rescheduled appointments could result in suspension of all dental and orthodontic services and dismissal from our dental practice.

Braces "Monthly Fee" / Hygiene visit $80 / General Dentistry $100

I have read and understand the Appointment Cancellation and Deposit Policy of the practice and I agree to be bound by its terms.

I, _____ (print name), have received a copy of the appointment Cancellation Policy and agree with the policy as well as understand that I may not be able to schedule future appointments unless fees are collected.

_____

Signature **Date**

Fees and Payments

Our fees are based on the current American Dental Association fee guide. Full payment for each phase of your treatment is required at the time of your appointment. For your convenience we accept cash, MasterCard, Visa, America Express or Discover Payments. We also offer payment plan though Lending club or CareCredit. For more information ask our front office.

Insurance

If you have dental insurance benefits, we will gladly submit a claim for services rendered on your behalf, to assist in prompt payment from your insurance company.

We will process your claim electronically. Proof of insurance will be requested at the time of each appointment. If your insurance provider changes, please let us know so that we may keep our records up to date and current.

Please note that your insurance policy is an agreement between you, your employer and the company providing the benefits, the insurance company will submit payment to our office for the converge in your particular plan, and you will be required to pay your estimated portion at the time of service.

Insurance companies vary greatly in compensation. They most often cover the most basic or even the least expensive form of treatment. Our goal is to provide you with the best treatment available and therefore we shall always give you our recommendations for the best treatment. The best recommendation may not always be covered by your insurance policy. Please keep this in mind when you are making your decision for lifelong dental care. When the policy does not cover what we recommend, only you as the patient have the right to decide whether you want to go forward with the treatment options that is the best for your health, or the treatment option that the insurance company covers but not result in the best possible outcome.

I have read and understand the office policy descried above.

PATIENT NAME: _____ **DATE:** _____

SIGNATURE: _____

Health History:

PLEASE CHECK ANY CONDITION THAT YOU CURRENTLY OR PREVIOUSLY SUFFER FROM:

__Aids/HIV __Alcoholism __Allergies __Anemia __Anorexia __Appendicitis __Arthritis __Asthma __Bleeding

__Bronchitis __Bulimia __Cancer __Cataracts __Chicken Pox __Diabetes __Emphysema __Epilepsy

__Fractures __Glaucoma __Heart Disease __High Blood Pressure __Heart Valve/Murmur __Hepatitis

__Herpes __High Cholesterol __Lupus __Low Blood Pressure __MS __Mumps __Nervous Disorders

__Neck/Back Problems __Pacemaker __Parkinson's __Polio __Psychiatric Care __Respiratory Problems

__Rheumatoid Arth __Rheumatoid Fever __Seizures/Fainting Spells __Sinus Problems __Stomach Ulcers

__Stroke __Thyroid Problems __Tonsillitis __Tuberculosis tumors/Growths __Ulcers __Venereal Disease

__Viral infections Whooping Cough __Flu __Colds __Fibromyalgia __Migraines __Other: _____

MEDICAL QUESTION:

List any medications you are taking including nonprescription drug:

_____

_____

_____

Are you allergic to any Medication? ___Yes ___No (If YES, please list below):

_____

_____

Are you in good health? ___ Yes ___ NO

Date of last Medical exam: _____

Have you ever been hospitalized? ___ Yes ___ No (If YES, what was the problem):

_____

_____

Have You any surgeries? ___ Yes ___ No (If YES, please explain):

_____

FOR WOMEN ONLY:

Are you taking birth control? __ Yes __ No

Are you nursing/breastfeeding? __ Yes __No

Are you pregnant? __ Yes __ No (**Due date**: _____)

Possibility of being pregnant? __ Yes __No

Dental History:

PLEASE CHECK ANY CONDITION THAT YOU CURRENTLY OR PREVIOUSLY SUFFER FROM:

__ Bleeding Gums __Broken Fillings __Chronic Bad Breath __Decayed Teeth __Food catches between teeth __Grinding teeth __Injury to teeth or jaw __Loose Teeth __Periodontal Treatment __Extractions __Sensitivity to hot, cold, sweet or pressure __Sores/swelling in mouth __TMJ

DENTAL QUESTION:

Date of last dental exam: _____

Name of previous dentist: _____

Reason of last visit: _____

Dental needs: _____

Name of general dentist office: _____

Phone number: _____

Do you have dental insurance? _____

How often do you floss? _____

Do gums bleed when you brush? Yes ___ No ___

Have you had any complication from an extraction? Yes ___ No ___ (If Yes, Explain)

_____

_____

Have you ever had Orthodontic treatment? Yes ___ No ___

If Yes, how long ago? _____

Have you ever had an allergic reaction to crown, metal filling, or dental application? Yes___ No___

On a scale from 1 to 10 (with 10 being the highest) how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile, what would it be?

__Whitening __Crowding/Crooked teeth __Jaw joint pain __Spaces __Missing teeth __Tooth shape __Dark teeth __Tooth size __Speech problems __Gummy smile __Overbite __Underbite __Facial profile Teeth are different colors __Ugly old crowns __Other: _____

Patient Signature: _____ **Date:** _____

HIPPA CONSENT FORM

I, _____ understand that under the Health Insurance Portability Act of 1996(HIPPA), I have certain right to privacy regarding my protected health information (PHI), I understand that this information can and will be used to:

Conduct plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessment and physician's certifications.

You have informed me of your notice of Privacy Practices, which contains a more complete description of the uses and disclosers of my health information. I have given the right to review such notice of Privacy Practices prior to singing this consent. I understand that this organization at any time at the address above to obtain a current copy of the notice of privacy practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restriction, but if do agree to them you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relaying on this consent.

Patient Name: _____

Signature: _____ **Date:** _____

Relationship to Patient: _____

FINANCIAL AGREEMENT

Our goal is to provide the highest quality of dental care possible and have clear communication of our financial policy.

ALL ACCOUNTS/PAYMENT ARE DUE AT THE TIME OF SERVICE. If a procedure requires multiple appointments, payments are required in full at the first appointment.

PAYMENT OPTION:

1. **Cash**
2. **MasterCard**
3. **Visa**
4. **Novus/Discover**
5. **ApplePay**

PATIENT WITH INSURANACE: the PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of service, OR the patient can sign a credit card authorization form to bill their credit card AFTER insurance has paid for visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

PARENTS NOT ACCOMPANYING THEIR CHILD to appointment must make PRIOR arrangements for payment (Cash, Credit Card authorization or call in a payment at (562)317-5258)

Parents accompanying their children are financially responsible for payment 18% annual interest is charged for any unpaid balance. A $15 fee is charged for nonpayment. There is a $30.00 processing charge for non-sufficient funds.

RECORDS: can be viewed at any time. There is a nominal charge for release or copies of records.

I _____, agree to these financial terms.

Signature: _____ **Date:** _____

PHOTOGRAPHY RELEASE

I Hereby authorize CDI Dental Group, to publish photographs/videos taken of me during dental office visit, and my name in likeness, for use in the CDI Dental Group print, online and video-based marketing materials, as well as other office publications.

I the patient/guardian release and hold harmless CDI Dental Group from any reasonable expectation of privacy or confidentiality associated with that images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other dental office publications, I acknowledge and agree that publication of photographs confers no rights of ownership or royalties.

I hereby release CDI Dental Group, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me (the patient) any third party in connection with my participation.

Print Name: _____

Patient/Guardian Signature: _____

Relationship to patient: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____