Central Arkansas Family Dentistry

Daniel C. Heard, DDS, PA

Welcome! Thank you for choosing Dr. Heard and the staff of Central Arkansas Family Dentistry for your dental healthcare needs. It is our goal to provide you with the highest quality dental care in a warm, caring environment. To help us meet your needs, please fill out the following forms completely. If you have any questions or need assistance, we will be happy to help you.

Today's Date: _____ Reason for Today's Visit: _____

Patient Information

Full Name: _____ Preferred Name/Nickname: _____ ☐ Male ☐ Female

Phone (Home): _____ (Cell): _____ (Work): _____Ext._____

Address: _____ City: _____State: _____ Zip: _____

Social Security # : _____ Birthdate: _____ Email Address: _____

Check Appropriate Box: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Patient's Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

If Student, Name of School: _____ ☐ Full ☐ Part-time

Whom may we thank for referring you to our office ☐ Another patient/relative (Name: _____)

☐ Dental Office ☐ Yellow Pages ☐ Website ☐ Kid's Directory ☐ Insurance Provider List ☐ Other _____

Health Information

- Date of Last Dental Visit: _____ Have you ever had a bad experience in a dental office? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any complications during/following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Primary Care Physician: _____ Phone: _____
- Are you currently being treated for a medical condition? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past five years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medication(s) including non-prescription medicine on a routine basis? ☐ Yes ☐ No
  If yes, please list: _____
- WOMEN ONLY: Are you taking oral contraceptives? ☐ Yes ☐ No Are you currently nursing? ☐ Yes ☐ No
  Are you currently pregnant? ☐ Yes ☐ No If so, expected due date: _____

Do you have or have you had any of the following? Please check all that apply:

☐ ADD/ADHD
☐ AIDS or HIV
☐ Arthritis
☐ Artificial/Joint Replacment
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pain
☐ Diabetes
☐ Dizziness
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Fainting Spells
☐ Fibromyalgia
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis C
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Therapy
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems/Ulcers
☐ Stroke
☐ Tuberculosis
☐ Thyroid Disease
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Sulfa Drug Allergy
☐ Other Drug Allergy _____
☐ Latex Allergy

OTHER Allergies:
☐ _____
_____

OTHER Conditions:
☐ _____
_____

Responsible Party

Name of person responsible for this Account: _____Relationship to Patient: _____
Marital Status: Married ____Single____Divorced____Seperated____Widowed____ Does Patient Live With You?_____
Address (if different from Patient's): _____
Street City State Zip Code
Name of Employer: _____ Work phone: _____

Birthdate: _____ Social Security #: _____ Is this person currently a patient? ☐ Yes ☐ No

Dental Insurance Information

Full Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birth Date: _____ Social or ID #: _____ Group #: _____

Policy Holder's Address: _____
Street City State Zip Code
Policy Holder's Employer: _____ Phone #: _____
Insurance Company Name: _____Phone #: _____

Claim Address: _____
Street City State Zip Code

Is the patient covered by additional Dental Insurance? ☐ Yes ☐ No If Yes, please fill out box below.

Secondary Dental Insurance Information

Full Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birth Date: _____ Social or ID #: _____ Group #: _____

Policy Holder's Address: _____
Street City State Zip Code
Policy Holder's Employer: _____ Phone #: _____
Insurance Company Name: _____Phone #: _____

Claim Address: _____
Street City State Zip Code

Is the patient covered by ARKids 1st Medicaid Coverage? ☐ Yes ☐ No If Yes, please fill out box below.

ARKids First

Name as it appears on card: _____ Birthdate: _____

ID# as it appears on card: _____ Do you pay a $10 co-pay for Doctor visits? ☐ Yes ☐ No

Person to contact in case of an emergency _____ Relationship to Patient _____

Phone (Home): _____ (Cell): _____ (Work): _____Ext._____

Authorization and Release:
I have read the above information and it is accurate to the best of my knowledge. I understand providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist. I authorize CAFD to perform my and/or my children's dental procedures. I authorize CAFD to release any information including the diagnosis, records of treatment, and x-rays rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I have read the financial policy of CAFD and agree to be responsible for payment of all services rendered on my behalf or my dependents. **I have also read or am familiar with the HIPAA Privacy Act and my signature below acknowledges receipt and understanding of HIPAA and the privacy policies of Central Arkansas Family Dentistry.**

Signature of patient (or parent if minor) _____ Date _____

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Financial Policy

Welcome to ***Central Arkansas Family Dentistry*** and thank you for trusting us to provide you with the highest quality dental care in a warm, caring environment. It is important to us that you understand our fees, services, and policies. We will be happy to answer any questions or concerns you may have. Once you have read the policies, please initial each section.

Payment Options

- **Payment is due the day service is provided.** For your convenience we accept cash, check, Visa, Mastercard, American Express, and Discover.
- Patients carrying an overdue balance will not be able to receive further treatment until the balance is paid or an approved payment plan is established.

If finances are a concern and you are unable to pay your balance in full the day your treatment is initiated, Dr. Heard will allow you to apply for a payment plan with our office or apply for financing through *Care Credit*. Our financial Coordinator will be happy to explain these payment options to you.

_____ I have read and understand the *Payment Options* available.

Dental Insurance

- Our office will file all dental claims with your insurance company; however, **we do require your deductible and estimated portion of the bill be paid at the time of service.**
- After we receive payment from your insurance company, you will be responsible for any remaining balance.
- If you disagree with any insurance coverage decisions or insurance payments you should contact your insurance company.

As a courtesy to you, our office will make every effort to help you understand your insurance coverage. However, your insurance policy is an agreement between you and your insurance company and you are ultimately responsible for knowing what your insurance will cover and not cover. We will do our best to help you with any questions you have regarding your insurance plan or benefits, but we do suggest you contact your insurance company for further verification of benefits.

_____ I have read and understand the *Dental Insurance* policies.

Missed Appointments

- We appreciate **48 hours notice** when canceling or rescheduling an appointment.
- After two missed appointments, you will be charged $25 for each additional appointment missed.
- If you cancel or reschedule two appointments in less than 24 hours before your appointment, you will be charged $25 for each additional appointment canceled or rescheduled.

_____ I have read and understand the *Missed Appointment* policies.

Text & Emails

- We communicate often with patients via phone calls, text messages, and email for appointment reminders and overdue balances. We may call or text any telephone number on your account, including wireless numbers, which could result in additional charges to you. Contact may include using a pre-recorded voice or an automated dialing device. Authorization will remain in effect until individually withdrawn by you in writing.

_____ I agree that CAFD or an agent of CAFD may contact me as described above.

_____ _____

Responsible Party Signature Office Party Signature