

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:

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

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 \$35 for each additional appointment missed.
- If you cancel or reschedule two appointments in less than 24 hours before your appointment, you will be charged \$35 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

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: _____ \$10 co-pay Yes No
ID# as it appears on card: _____ MCNA OR Delta Dental Smiles

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 _____