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 need any assistance, we will be happy to help you.

Today's Date: _____ **Date of Last Dental 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: _____

Whom may we thank for referring you to our office: (check all that apply)

☐ Another happy patient (Name: _____) ☐ Another Dental Office referred you

☐ Google search/positive reviews ☐ Website ☐ Social Media ☐ Insurance Provider List ☐ Other_____

DENTAL HEALTH HISTORY

- What led you to schedule an appointment with us? Check all that apply: ☐ I've heard great things about Dr. Heard & CAFD ☐ I know my dental health is very important and worth investing in ☐ I am having a dental problem I need help with ☐ Your office was on my insurance provider's list ☐ I'm interested in ways to improve my smile
- In thinking about previous dental care, what have you experienced that you would hope to find at CAFD?

_____

- What experiences would you like to avoid? _____
- Are there time, money, or other considerations that you want us to understand? _____
- Is there anything about your mouth, teeth, or smile that you wish were different? _____
- Is there anything else we should know about you as we partner together to maximize your dental and overall health?

_____

HEALTH HISTORY

- Are you currently under the care of a physician 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: _____
- Do you pre-medicate for dental visits? ☐ Yes ☐ No
  If yes, please explain: _____
- 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 Replacement
- ☐ 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:

- ☐ _____
- _____

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

If yes, please explain: _____

EMERGENCY CONTACT

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

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

RESPONSIBLE PARTY

If the patient is a minor, who is responsible for financial arrangements?

Name of person responsible for this Account: _____Relationship to Patient: _____

Marital Status: Married ____Single____Divorced____Seperated____Widowed____

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

CAFD POLICIES & CONSENT FOR SERVICE:

OFFICE POLICIES:

- **Payment is due the day service is provided.** 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.
- We appreciate **48 hours notice** when canceling or rescheduling an appointment. After two per calendar year missed appointments or appointments changed with less than 24 hours notice, you will be charged $35 for each additional appointment missed or changed.
- We communicate often with patients via phone calls, text messages, and email for appointment reminders and financial arrangements. **Please do not "opt-out" of our automated text reminders as this will also disable our ability to text one on one with you**. We can disable the automated messages/reminders for you if you do not wish to receive them.

DENTAL INSURANCE POLICIES:

- 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.

AUHORIZATION & RELEASE:

All of the information I have provided to CAFD 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 authorize CAFD to contact me via phone, text, and email and to leave messages pertaining to dental appointments on my voicemail or with immediate family members. 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 and/or parent of minor Date

PRIMARY DENTAL INSURANCE INFORMATION

Full Name of Subscriber _____ Relationship to Patient: _____
Subscriber's Birth Date: _____ Social or ID #: _____ Group #: _____
Subscriber's Address if different from patient:
_____
Street City State Zip Code
Subscriber's Employer: _____ Phone #: _____
Insurance Company Name_____ Phone #: _____
Claim Mailing 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 Subscriber _____ Relationship to Patient: _____
Subscriber's Birth Date: _____ Social or ID #: _____ Group #: _____
Subscriber's Address if different from patient:
_____
Street City State Zip Code
Subscriber's Employer: _____ Phone #: _____
Insurance Company Name_____ Phone #: _____
Claim Mailing 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: _____ $10 co-pay? ☐ Yes ☐ No