Dental Associates of Cumberland

A Dental Wellness Center

Name:_____
(Last) (First) (MI) (Title)

Preferred Name:_____ ( )Male ( )Female

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

SSN:_____ DOB:_____

Home Phone: (___)_____ Work Phone: (___)_____

Cell Phone: (___)_____ **E-mail Address**:_____

Employer:_____ Occupation:_____

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Separated ( )Domestic Partner

How did you hear about our office?_____

Do you prefer to be contacted for appointment confirmation via e-mail / text / phone? (Please circle one)

- Insurance—Primary

Subscriber Name:_____ Relationship to Patient:_____ Subscriber DOB:_____

Subscriber ID#:_____
Insurance Company Name:_____

Insurance Company Phone:_____

Do you have Secondary Insurance? ( )Yes ( ) No

- Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____

Relationship:_____ Date:_____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature:_____

2138 Mendon Road, Cumberland Medical Center, Suite 202, Cumberland Hill, RI 02864
Tel 401.723.0350 Fax 401.723.4856
drfelix@cumberlandsmile.com www.cumberlandsmile.com

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Medical History

Name:_____
(Last) (First) (MI) (Title)

Physician's Name:_____ Physicians Phone #:(____)_____

Date of last visit:_____

Your current physical health is: ( )Good ( )Fair ( )Poor

Emergency contact:_____ Relationship:_____ Phone:(____)_____

Do you use tobacco in any form? ( )Yes ( )No

If so, what kind and how often:_____

Have you had any metal rods, pins or implants placed? ( )Yes ( )No

Are you taking any medication? ( )Yes ( )No

Please list each one:_____

Have you ever had any surgical procedures? ( )Yes ( )No

Please list each one:_____

Yes	No	Conditions	Yes	No	Conditions
( )	( )	Abnormal Bleeding	( )	( )	Heart Attack
( )	( )	Allergies	( )	( )	Heart Murmur
( )	( )	Anemia	( )	( )	Heart Surgery
( )	( )	Angina Pectoris	( )	( )	Hemophilia
( )	( )	Arthritis	( )	( )	Hepatitis
( )	( )	Artificial Heart Valve	( )	( )	High Blood Pressure
( )	( )	Asthma	( )	( )	Joint Replacement
( )	( )	Autoimmune Disorder	( )	( )	Kidney Problems
( )	( )	Blood Transfusion	( )	( )	Liver Disease
( )	( )	Cancer	( )	( )	Low Blood Pressure
( )	( )	Chemotherapy	( )	( )	Mitral Valve Prolapse
( )	( )	Congenital Heart Defect	( )	( )	Pace Maker
( )	( )	Development Disorder	( )	( )	Psychiatric Problem
( )	( )	Diabetes	( )	( )	Radiation Therapy
( )	( )	Difficulty Breathing	( )	( )	Rheumatic Fever
( )	( )	Emphysema	( )	( )	Seizures
( )	( )	Epilepsy	( )	( )	Sexually Transmitted Disease
( )	( )	Facial Surgery	( )	( )	Sinus Problems
( )	( )	Fainting Spells	( )	( )	Stroke/TIA
( )	( )	Frequent Headaches	( )	( )	Substance Abuse
( )	( )	Glaucoma	( )	( )	Thyroid Problems
( )	( )	HIV/AIDS	( )	( )	Tuberculosis

Yes	No	Allergies
( )	( )	Aspirin
( )	( )	Codeine
( )	( )	Dental Anesthetics
( )	( )	Erythromycin
( )	( )	Latex
( )	( )	Penicillin
( )	( )	Sulfa
( )	( )	Tetracycline
( )	( )	Other:_____

If Female, Please Answer:

Yes	No	
( )	( )	Are you taking Birth Control Pills?
( )	( )	Are you Pregnant If so, how many weeks?_____
( )	( )	Are you Nursing?

Do you have any condition not listed above? If so, Please explain_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ Date:_____

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Thank you for choosing us as your dental care provider. Our primary concern is that you receive the appropriate treatment needed to restore and maintain optimal dental health. We also realize the importance of good communication with our patients regarding their treatment, the fees involved and our Financial Policy.

We ask that all patients read and sign the following Financial Policy. The signed copy will be kept with your records here at Dental Associates of Cumberland.

Payments are due at the time services are rendered.

Payment Options:

1. Cash---includes money orders and personal checks.
2. Visa/MasterCard (Debit/Credit Card)
3. CareCredit and Springstone---the monthly payment plan we offer for services over $300.00 as a separate line of credit to cover you and your family members' health care needs.
    - Approval usually only takes a few minutes
    - They offer No Interest Option
    - They also offer low interest Extended Payment Plan options, for more time to pay your balance.
    - No annual fees or prepayment penalties
4. Flexible Spending Accounts

Insurance

We do accept most dental insurance plans and assignment of benefits. We are happy to submit claims providing we have all necessary information. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
Please understand that:

1. We cannot render services on the assumption an insurance company will pay the charges. All charges are your responsibility from the date the services are rendered.
2. Deductibles and co-payments are due at the time of service. Please note these deductibles and co-payments are best estimates.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Remember; please update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.

I HAVE READ THE POLICIES DESCRIBED IN THIS FORM. I AGREE TO ABIDE BY THE TERMS OUTLINED. I UNDERSTAND AND ACCEPT MY FINANCIAL RESPONSIBILITY.

SIGNATURE **DATE**