

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:

- | | | | |
|---|---|--|---|
| <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 | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Stomach Problems/Ulcers | |
| <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 | |

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 _____ Separated _____ 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

AUTHORIZATION & RELEASE:

• **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.

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

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.