CERVANTES & PRADO DENTAL CARE, INC
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www.cpdentalcare.com

Patient Information Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Nickname _____

Address: Street _____ City _____ State_____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

By providing your e-mail address you agree to receive (check one or both) Appointment Reminders Practice Newsletter

What is your preferred method of contact? Home Phone Work Phone Mobile Phone E-mail

Social Security Number _____ **Date of Birth** _____

Drivers License # _____ **State** _____

Patient Employed By _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State _____

Sex Male Female **Marital Status** Married Single Divorced Separated Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ **Home Phone** _____ **Mobile Phone**_____

Is the patient a Minor? Yes No **Full-time Student** Yes No **Name of school** _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ **Relationship to Patient** Self Spouse Parent Other _____

If patient is a Minor, primary residency Both parents Mom Dad Step Parent Shared Custody Guardian

Address (if different from patient) Street _____ City _____ State ____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer (if different from above) _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State ____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ **Phone** _____

Address: Street _____ City _____ State ____ Zip_____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name

Address: Street _____ City _____ State ____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number**_____

Policy Number _____ **Patient Relationship to Insured** _____

Medical Plan Information

Plan Name _____ Phone_____

Address: Street _____ City _____ State _____ Zip_____

Name of Insured _____ Date of Birth _____ ID Number_____

Policy Number _____ Patient Relationship to Insured _____ Deductible amount_____

Whom may we thank for referring you?

One of our valued patients (name of patient) _____

Advertisement _____ Local Dental Society _____

Our Web site Other _____

Please list other members of your immediate family who are patients in our practice

_____ _____ _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Cell Phone Use: Please refrain from using your cell phone in the treatment area. Please let a staff member know if you need to step out to make a call. Cell phone usage in the treatment area disrupts the doctor and staff, as well as other patients. _____(Initials)

Payment: Payment is due at the time of services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, credit/debit. I understand that if I provide a cell phone contact, Cervantes and Prado Dental Care or its representative may use that phone number to contact me about medical, dental, billing or other issues.

**Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental plans to understand and maximize their coverage. Insurance coverage is only an estimation. Patient is responsible for all treatment not covered by the insurance.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patientõs portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service.

If we are not a contracted provider with your dental benefit plan, it is the patientõs responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you õassign benefitsòto us. In this circumstance, you are responsible and will be billed for any unpaid balances for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not õassign benefitsòto our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to out practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienistõs time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the upmost service and care, we do require 48-hour notice to reschedule or cancel an appointment. With less than 48-hour notice, a fee of $50 for every 30 minutes or deposit to reserve the appointment time again, may be required. To serve all our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival a fee of $50 or deposit to reserve the appointment time again, may be required.

Authorization: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize release of the information required to process my claims of dental benefits. I authorize payment directly to this doctor otherwise it will be paid to my _____ (initial)

I herby acknowledge that a copy of this practiceõs Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet._____ (initial)

Signature_____ Date_____