ADVANCED
Dental Care & Facial Aesthetics

PATIENT REGISTRATION INFORMATION

Patient Name _____
(Last) (First) (MI)

Address_____
(Street) (City) (State + Zip)

Home Phone Number _____ **Cell Phone Number** _____

Date of Birth_____ **Sex:** M/F **Marital Status**: Married/Single/Widowed/Divorced

1. **SSN** _____**How did you hear about our office?** _____

Patient Employer/School _____**Work Number**_____

Email address_____**Occupation**_____

Spouse/Parent Name _____

Address _____**City/State**_____

Home Phone Number _____ **DOB**_____ **SSN**_____

EMERGENCY CONTACT

Name_____**Home/Cell Number** _____

INSURANCE INFORMATION (Primary)

Subscriber Name_____ **Relationship to Patient:**_____ **DOB**_____

SSN_____ **Home/Cell Number**_____ **Work Number**_____

Employer_____ **Insurance Carrier**_____ **Member ID/Group#**_____

Address _____ **Phone Number** _____

SECONDARY INSURANCE

Subscriber Name_____ **Relationship to Patient:**_____ **DOB**_____

SSN_____ **Home/Cell Number**_____ **Work Number**_____

Employer_____ **Insurance Carrier**_____ **Member ID/Group#**_____

Address _____ **Phone Number** _____

ASSIGNMENT AND RELEASE – PRIMARY INSURANCE

I, the undersigned, have insurance with_____
Name of Insurance Company

I assign all benefits directly to Dr. Martin Cisneros, if any, otherwise payable by me for services rendered. 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 payment of all benefits, and use of this signature on all insurance submissions whether manual or electronic.

Signature of Insured/Guardian_____ Date_____

ASSIGNMENT RELEASE – SECONDARY INSURANCE

I, the undersigned, have insurance with_____
Name of Insurance Company

I assign all benefits directly to Dr. Martin Cisneros, if any, otherwise payable by me for services rendered. 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 payment of all benefits, and use of this signature on all insurance submissions whether manual or electronic.

Signature of Insured/Guardian_____ Date_____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental
Name of Minor/Child
staff to perform necessary dental services for my child. This includes and is not limited to, x-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Insured/Guardian_____ Date_____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. Our invoices are due and payable upon receipt. **If such balance is not paid in full within (90) days of the date the invoice is rendered, the outstanding portion may be referred for collection. I agree that all fees charged by the collections agency shall be my responsibility.**

Signature of Insured/Guardian_____ Date_____

MEDICAL HISTORY

Medical Doctors Name_____ Phone Number_____

Are You Under a Doctors' Care Now? Y/N If Yes, Why?_____

Are You Allergic to: Penicillin Codeine/Aspirin/Local Injected Anesthetic/Latex/Acrylic Other:_____

Are You Taking any Medications? Y/N If Yes, What?_____

Are You Pregnant? Y/N If Yes, How far along?_____

Have You Ever Been Told By Your Physician To Pre-Medicate Before Dental Visits? Y/N If Yes, With What Medications?_____

Do You Smoke? Y/N If Yes, How Much?_____ How Many Years?_____

PLEASE CHECK ALL THAT APPLY:

Mitral Valve Prolapse	Chest Pain	AIDS(HIV)	Sinus Trouble	Cancer
Heart Murmur	Swelling of Ankles/Feet	Venereal Disease	Cortisone Medication	X-ray/Cobalt Treatment
Congenital Heart Lesion	Shortness of Breath	Herpes	Recent Weight Loss	Chemo/Radiation
Heart Surgery	Fainting or Dizziness	Cold Sores	Diabetes	Arthritis/Gout
Heart Pacemaker	Blood Disease/Disorder	Fever Blisters	Excessive Thirst	Rheumatism
Artificial Heart Valve	Anemia	Lung Disease	Kidney Trouble	Artificial Joints
Rheumatic Fever	Sickle Cell Anemia	Tuberculosis	Thyroid Disease	Pain in Jaw Joints
Scarlet Fever	Hypoglycemia	Emphysema	Parathyroid Disease	Nervousness
Stroke	Hemophilia	Frequent Cough	Liver Disease	Psychiatric Care
Epilepsy	Blood Transfusion	Asthma	Hepatitis	Alzheimer's
High Blood Pressure	Bruise Easily	Allergies	Jaundice	Drug Addiction
Low Blood Pressure	Glaucoma	Hay Fever	Ulcers	Seizures

Do You Have Any Other Conditions That May Not Be Listed Above? Y/N If Yes, What? _____

Name and Phone Number of Previous Dentist:_____

Are You Having Pain Or Sensitivity? If So, Where At?_____

How Would You Rate Your Smile and Oral Health? 1 2 3 4 5 6 7 8 9 10

How Important Is It To You To Improve Your Oral Health? 1 2 3 4 5 6 7 8 9 10

Date Of Last Dental Visit:_____ Were X-Rays Taken? Y/N

Have You Ever Had A Problem With Dental Treatment? Y/N Do You Wear Partials Or Dentures? Y/N

Do Your Gums Bleed Easily? Y/N Have You Ever Had Gum Surgery? Y/N

Do You Gag Easily? Y/N Do You Clench Or Grind Your Teeth? Y/N

Please Add Anything Else You Feel Is Important For Us To Know:_____

_____

OFFICE FINANCIAL POLICIES

PAYMENT

Full payment is due on the day services are rendered. We gladly accept cash, check, MasterCard, Visa, and Discover. If you are unable to pay in full, please make arrangements with the front desk prior to starting treatment.

LARGE CASE PAYMENTS

If financing application is accepted through CareCredit. Payments may be financed for a period of 6,12,18, or 24 months with no interest. We also have financing for a period of up to 60 months for a low interest rate.

DENTAL INSURANCE

Insurance filing is a **courtesy** provided to the patients **and is in no way a responsibility of the office**. We file your primary insurance and secondary insurance. Children that are covered by two insurance plans generally fall under the "birthday rule" if there are two plans, so the parent with the earliest birthday in the year is the primary carrier.

Your insurance coverage is determined by what your employer has purchased. Payments for services can vary widely from policy to policy. Some procedures may be denied based on age, pre-existing conditions or length of time in the plan. These restrictions are based on your specific plan as determined by your employer's contract with the insurance company. If you are unsure about your insurance coverage, we advise **you** to contact your dental insurance carrier for information and clarification about you benefits. **We can make no guarantees of your insurance reimbursement.**

UCR's (usual and customary rates) are applicable only to plans with which we participate as a PPO (Preferred Provider Organization).

BROKEN AND CANCELLED APPOINTMENTS

By signing below, I certify that I have read the financial policies (stated above) and understand these policies. I agree to abide by the policies above for treatment provided by Dr. Cisneros. I certify that all information provided is correct, authorize the doctor and staff to release personal information to the insurance company for all persons on my account. I understand that the account balance is ultimately my responsibility regardless of insurance coverage and payments**. If such balance is not paid in full within ninety (90) days of the date the invoice is rendered, then the outstanding portion may be referred for collection. I agree that all fees charged by the collection agency shall be my responsibility.** I understand and agree that the terms herein are reaffirmed each time services are rendered.

Signature of Insured/Guardian_____ Date_____