C-Bar Dentistry
Keep Your Smile Bright

Patient Name: **Account #:** **Patient Code:** **Date:**

Patient, Pharmacy and Insurance Information

Patient Information

Prefix:_____ First Name:_____ Middle Name:_____ Last Name: _____

Suffix: _____

Street:_____ Zip:_____ City:_____ State:_____ Country: _____

Preferred Phone #:_____ Is this a mobile number? Yes ☐ No ☐

Email Address: _____

Date of Birth:_____ Sex: ☐ Male ☐ Female ☐ Unspecified

Emergency Contact:_____ Emergency Phone #: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Responsible Party

First Name:_____ Middle Name:_____ Last Name: _____

Street:_____ Zip:_____ City:_____ State:_____ Country: _____

Date of Birth:_____ Sex: ☐ Female ☐ Male ☐ Unspecified

Responsible Party Signature:_____ Date: _____

Preferred Pharmacy

Name:_____ Phone Number: _____

Street:_____ Zip:_____ City:_____ State: _____

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name:_____ Middle Name:_____ Last Name: _____

Employer Name:_____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number:_____ Group/Contract Number: Date of Birth:

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Secondary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name:_____ Middle Name:_____ Last Name: _____

Employer Name:_____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number:_____ Group/Contract Number:_____ Date of Birth: _____

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Patient Name: Account #: Patient Code: Date:

Health History

Reason for Visit: Broken Tooth Check-up Cosmetic Dentures Tooth Pain Other: _____
Height:_____ft_____in Weight:_____Patient Date of Birth: _____
Are you under the care of a primary physician? Yes No
Primary Physician's Name:_____Physician's Phone Number: _____
Date of Last Physical:
I don't know exact date Last 6 months 6 months - 1 year 1-3 years Greater than 4 years Never Other:_____
Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? Yes No
Have you ever been hospitalized? Yes No
Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?
No Yes How Long? _____
Do you require antibiotics prior to dental procedures? Yes No
Are you allergic or have you had an adverse reaction to any of the following?
None Amoxicillin Aspirin Codeine Epinephrine Latex Metals Novocain Penicillin Sulfa Tetracycline
Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:
None

Check any conditions that apply to you:

None
Alcoholism
Allergies or Hives
Anemia
Arthritis
Artificial Joint/Pins
Type:_____
Age:_____
Aspirin Therapy
Asthma
Blood Thinners
Blood Transfusion
Breathing Problems
Cancer
Type:_____
Chemotherapy
Coumadin Therapy
Dementia
Diabetes
Type:_____
Dialysis
Drug Addiction
Epilepsy
Excessive Bleeding
Fainting/Dizziness
Hearing Impairment
Heart Murmur
Heart Surgery
Date: _____
Heart Trouble
Type:_____
Hepatitis
Type:_____
High Blood Pressure
HIV
Kidney Disease
Liver Disease
Low Blood Pressure
Lung Disease/COPD
Lupus
Mitral Valve Prolapse
Mobility Impairment
NON-DENTAL Implants
Type:_____
Organ Transplants
Type:_____
Pace Maker
Psychiatric Care
Radiation Therapy
Radiosurgery
Rheumatic Fever
Seizures
Sexually Transmitted Disease
Sinus Problems
Stomach Problems
Stroke
Thyroid Disease
Tuberculosis(TB)
Ulcers
Visual Impairment
Other Disease/Illness
Type: _____

Dental History

Date of Last Dental Visit:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Date of Last Dental X-ray:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? ☐ Yes ☐ No

Age of dentures: ☐ Less Than 6 Months ☐ 6 months-3 years ☐ Greater than 4 years

Please check any conditions that apply to you below:

☐ Pain In Jaw(TMJ) ☐ Teeth Grinding/Clenching ☐ Use Tobacco Products Mouth Sores

☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date: _____

Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature:_____ Date: _____

Dr's Signature/Medical History Review:_____ Date: _____

6 MONTH UPDATE

Patient's Signature:_____ Date:_____

Dr's Signature/Medical History Review:_____ Date: _____

Patient Signatures

Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature:_____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

☐ all treatment information

☐ information specifically related to these treatment dates

Starting Date:_____ End Date: _____

Consent to obtain patient medication history (Optional)

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature:_____ Date: _____

Payment, Insurance and Financial Arrangement Policies (signed by ALL new patients)

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature:_____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Notice of Privacy Practices (must be signed by ALL new patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature:_____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

FINANCIAL POLICY

Your C-Bar Dentistry practice is committed to providing exceptional service and treatment that addresses both your short- and long-term needs. With our Peace of Mind Promise™, we make it easier for you to get the care you need at affordable prices—no hidden fees, no surprises.

1. A Clear, Written Estimate on your Cost of Treatment

Your dentist will provide you with a comprehensive treatment plan based on your overall health. You'll also receive a clear, detailed estimate of the cost of your plan, including your estimated insurance benefits. If you have questions regarding your insurance coverage, please contact your insurance company.

2. Payment Policy

Full payment of what you owe (called the Patient Financial Responsibility amount, as noted in your Treatment Acceptance and Payment Arrangement Form), is due when services are rendered. We accept cash, personal checks, Visa®, Master Card®, American Express®, Discover®, assigned insurance benefits, and select third-party financing programs.

3. Refund Policy

If you are reconsidering treatment you have not yet received but have already paid for, you may cancel treatment and request a refund at any time for the amount you paid. Note: Crown and bridge patients are responsible for the full cost of their treatment plan once preparation of your teeth has begun. Invisalign patients are responsible for the full cost of all laboratory costs and scan fees once fabrication of your aligns has begun.

Your refund request will be handled as follows:

• Original Form of Payment: Refunds will be applied to the original form of payment, with the exception of cash payments, which will be refunded by check.

• New Patients - 7 Days of Inactivity: If you are a new patient who hasn't had any treatment performed, has no scheduled appointments, and has a credit balance on your account, you will automatically receive, after 7 days of inactivity, either (a) a notice that you are entitled to a refund if you paid by cash or check, or (b) an automatic refund to your original form of payment if you paid by credit card or with third-party financing.

• 60 Days of Inactivity (*Massachusetts patients see below): Credit balances on accounts after 60 days of inactivity will be automatically refunded to the original form of payment, with the exception of cash/check payments, which will be notified by letter.

• Partial Denture Patients – 180 Days of Inactivity: Credit balances existing on accounts after 180 days of inactivity will be automatically refunded to the original form of payment, except cash payments, which will be refunded by check.

* Massachusetts Patients: Credit balances on accounts after 45 days of last deposit with no future appointment will be automatically refunded to the original form of payment, with the exception of cash/ check payments, which will be notified by letter. Credit balances on accounts of denture patients after 45 days of inactivity will be automatically refunded to the original form of payment, except cash/check payments, which will be notified by letter.

Timing of Refund

Cash/Check: After receiving your refund request, we will confirm that your payment has cleared the bank (which may take up to 15businessdays). Once cleared, you will be issued a refund check within 10 business days (5 business days for Massachusetts patients).

Credit Card/Third-Party Financing: Refunds will be issued to the form of payment within 3 business days after receipt of your refund request. Refunds for credit card payments may take up to seven (7) business days.

FINANCIAL POLICY

Three Ways to Request a Refund

•Contact your C-Bar Dental office

•Email a refund request to: info@cbardentistry.com, or

•Mail a refund request to:

C-BAR DENTISTRY
1702 S. DIXIE HWY STE C-1
LAKE WORTH, FL 33460

For more information on refunds, visit: https://www.cbardentistry.com/services

4. Dental Insurance
If you have dental insurance, your insurance claim will be processed as follows:

•In Network: If your dentist is a participating provider in your insurance network, you will be billed according to the terms of your dentist's agreement with your insurer.

•Out of Network: If your dentist is not participating or in-network provider with your insurance plan, we will honor your carrier's in-network fee structure. If your insurance carrier will not accept your assignment of benefits to your dentist, you are responsible for the estimated insurance benefit.

Insurance Discounts: Insurance companies often negotiate discounts for services provided to their plan members. If you exceed your annual benefit limit the insurer's discounted rate may apply to additional services as a benefit to you.

5. Third-Party Financing
Your C-Bar Dentistry practice accepts payment from non-affiliated, third party finance companies. Credit decisions are the responsibility of these third-party finance companies. You may choose to pay all or a portion of your treatment using approved third-party financing products.

6. Patient Satisfaction Inquiries
If you have an issue that cannot be resolved by your office team, please contact the Patient Satisfaction Hotline at 1-561-318-8762 or info@cbardentistry.com

7. Patient Communication
We'd like to keep in touch regarding your upcoming appointments, treatment plan, and treatment status. By providing your email address, phone number, and mailing address, you are giving C-Bar Dentistry permission to contact you through one or all of these communication methods. Note that email and text messaging is not secure and there is a risk that they could be read by a third party. By sharing your email or mobile number with us you are acknowledging that you are aware of this risk and agree to receive this type of communication. C-Bar Dentistry will limit the type of information in the messages. To opt out of communications, call our Patient Satisfaction Hotline at 1-561-318-8762.