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?

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- 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:

- ☐ ADD/ADHD
- ☐ AIDS or HIV
- ☐ Arthritis
- ☐ Artificial/Joint Replacement
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems/Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Drug Allergy
- ☐ Other Drug Allergy ________________
- ☐ Latex Allergy

OTHER Allergies:
☐ ________________
____

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____Seperated____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.

COVID-19 Screening Questions

Are you or anyone accompanying you experiencing any of the following symptoms?
(check all that apply)

- ☐ Fever (99.6 or higher), chills or sweating
- ☐ New or worsening cough
- ☐ Shortness of breath and/or trouble breathing
- ☐ Reduced sense of smell and/or taste
- ☐ Flu-like symptoms such as headache, muscle pain, fatigue
- ☐ None of the Above

Have you been in contact with any confirmed COVID-19 positive individuals in the last 14 days?

- ☐ YES
- ☐ NO

Have you been tested for COVID-19?

- ☐ YES-results negative
- ☐ YES-results positive
- ☐ NO

In the last 14 days, have you traveled internationally or to a COVID-19 hotspot area?

- ☐ YES
- ☐ NO

Do you have any of the following conditions: (check all that apply)

- ☐ Auto-immune disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ None of the Above

Dental Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID19, also known as “Coronavirus,” at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. “Social Distancing” nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, dental staff and sometimes other patients at all times.

By signing this form, you accept the risk and consent to treatment.

____________________________________ __________________

Signature of patient and/or parent of minor Date