CARDINALE DENTISTRY

PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____ MI: _____

Sex: M/F_____ Marital Status: (Single/Married/Divorced)_____

Date of Birth: _____ Social Security Number: _____

Occupation: _____ **Seasonal:** Yes ☐ No ☐

COPY OF DRIVER LICENSE REQUIRED

Address:_____Apt. #_____

City: _____State: _____Zip: _____

Seasonal Address (If Applicable): _____

Home Phone: _____Work Phone: _____EXT:_____

Cell Phone: _____ Email: _____

CONTACT PREFERENCE for CONFIRMING APPOINTMENTS: EMAIL OR TEXT (please circle)

EMERGENCY CONTACT:

Name: _____Phone #: _____

Relationship: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

FINANCIAL POLICY

To avoid any misunderstanding regarding our financial policy, we ask patients to read and sign this policy before treatment can be rendered.

1. Payment is expected in full at the time services are rendered. We accept cash, checks, debit cards, and all major credit cards.
2. We offer a two payment option for crowns, bridges, partials etc. You pay one-half of your balance at the first appointment and the second half at the delivery date appointment.
3. We offer Care Credit, a healthcare credit card specifically designed to pay for treatments. They offer a 6 month and 12 month interest free plan and extended payment plans with low interest. You can apply for this credit card online or by phone; you will receive a decision almost instantly. Ask our Treatment Plan Coordinator for a brochure.

Signature:_____Date:_____

DENTAL INSURANCE

Who is responsible for this account? _____Relationship to patient_____

Insurance Carrier: _____Phone #: _____

Employer:_____Group #: _____ID#/SSN: _____

Subscriber Name: _____Subscriber Date of Birth: _____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependents(s), have insurance coverage with _____

and assign directly to Vincent P. Cardinale, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

After your insurance benefits are verified, and as an added service to our patients, we will submit your insurance claims for you. We do not get involved with secondary insurance companies or Cobra plans; this will be your responsibility. You will be responsible for all deductibles and estimated co-payments at the time services are rendered. Some insurance companies have an undisclosed fee schedule or will only reimburse the insured and NOT the provider. In these cases, payment is expected in full and you will get reimbursed from your insurance company.

I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the dentist; therefore, my insurance company may pay less than the actual bill for services and I am still responsible for all dental fees incurred.

_____

Signature of Patient or Legal Guardian

_____

Printed name of Patient or Legal Guardian Date

CARDINALE DENTISTRY - MEDICAL HISTORY FORM

Patient Name: _____ Age: _____

Name of Physician: _____ Physician Phone #: _____

1. Have you been under the care of a medical doctor during the past 2 years or have had major surgery in the past 10 years? □ Yes □ No
   Reason? _____
2. Have you been hospitalized during the past 2 years? ☐ Yes ☐ No
   Reason? _____
3. Are you now taking any medications or drugs? Please include ALL: _____
   _____
4. Are you allergic to (i.e. itching rash, swelling of the hands, feet or eyes) or made sick by penicillin, latex, aspirin, acrylic, metal, local anesthetics, codeine, sulfa or any other drugs or medications? ☐ Yes ☐ No
   Please list: _____

Please circle any of the following which you have had or have at present:

AIDS	CANCER TREATMENT	HEART DISEASE/ATTACK	RADIATION TREATMENT
ALLERGIES/HIVES	CHEMOTHERAPY	HEART MURMUR	RECURRENT MOUTH SORES
ALZHEIMER'S DISEASE	CHRONIC FATIGUE	HEART PACEMAKER	RHEUMATIC FEVER
ANEMIA	CONGENITAL HEART DISORDER	HEART RHYTHM DISTURBANCE	SINUS TROUBLE
ANGINA PECTORIS	DIABETES	HEART SURGERY	SMOKER/TOBACCO USE
ARTHRITIS	DRUG/ALCOHOL ABUSE	HEMOPHILIA	STROKE
ARTIFICIAL HEART VALVES	EMPHYSEMA	HEPATITIS	THRYOID DISEASE
ARTIFICAL JOINTS	EPILEPSY OR SEIZURES	HIGH BLOOD PRESSURE	TMJ TREATMENT
(KNEE,HIP,SHOULDER)	EXCESSIVE BLEEDING	HIV CARRIER	TUBERCULOSIS
ASTHMA	FAINTING/DIZZY SPELLS	MITRAL VALVE PROLAPSE	ULCERS
BLOOD DISORDERS	GLAUCOMA	PSYCHIATRIC TREATMENT	

6. Women: Are you pregnant? ☐ Yes ☐ No Is there a possibility you are pregnant? ☐ Yes ☐ No
   Are you nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. By signing this form I acknowledge that I have read it completely and understand its contents.

Date _____ Signature of Patient or Legal Guardian _____

Date _____ Signature of Dentist _____

.....*Update below to be filled out at next annual appointment*.....

UPDATES

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No
For what conditions? _____

Are you taking any new medications? If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

CARDINALE DENTISTRY

DENTAL HISTORY

Patient Name:_____Date:_____

What is your main dental problem or purpose of this visit ? _____

_____

Date of your last dental visit _____Former Dentist:_____ Phone/Email_____

Reason for your last visit? _____

Do you have access to any of your x-rays or dental records?_____

Please answer the following questions about your dental health:	**Please Circle**	
Have you ever had an allergic reaction? If yes, to what?_____	YES	NO
Have you ever had any complications during or following dental treatments?	YES	NO
Do your gums bleed on brushing or flossing?	YES	NO
How often do you floss?_____		
How often do you brush?_____		
Do you find food collects between teeth?	YES	NO
Are any of your teeth sensitive to heat, cold, sweets or pressure?	YES	NO
Do you grind your teeth or clench your jaws?	YES	NO
Do you have pain or clicking in the jaw joint?	YES	NO
Do you regularly have soreness in your jaw muscles?	YES	NO
Do you get headaches?	YES	NO
Are there any sores or growths in your mouth now?	YES	NO
Do you want your teeth whiter?	YES	NO
Have you ever been told to take antibiotics prior to dental treatment?	YES	NO
Have you ever been told you have gum disease?	YES	NO
If yes, have you ever been treated for gum disease?	YES	NO
If yes, what treatment did you have _____ and where_____?		
Are you happy with your smile?	YES	NO
Do you have problems with bad breath?	YES	NO
Is there anything else that you think we should know about your care and treatment in this office?	YES	NO

If YES, please explain:_____

_____

Please rate in order of importance your primary concerns regarding your dental care.

_____Preventive dental health care _____Cost and affordability

_____Excellence and quality of service _____Other_____

Thank you for taking the time to assist us in getting to know you. We look forward to a long and happy professional relationship.

CARDINALE DENTISTRY

NOTICE OF PRIVACY/CONSENT FORM
HIPAA

PATIENT GIVING CONSENT

PRINT NAME: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We may use and disclose health information to call your home or other contact information to remind you of an appointment or that it is time to make an appointment at this office. You have the right to revoke this consent, in writing, signed by you, at any time. However, such revocation shall not affect any disclosure we may already have made in reliance on your prior consent. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996. (HIPPA)

Notice of Privacy Practices: You have the right to review our Notice of Privacy Practices before signing. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our notice, you may obtain a revised copy by contacting our office.

The patient understands that:

1. **Information may be disclosed to other providers who may be involved in your continuing care and course of treatment directly and indirectly. The information shared via email will not be encrypted.**
2. **Information may be disclosed to obtain reimbursement from your insurance company that we have on file for payment to the provider or you for services performed.**
3. **Information may be disclosed for all billing and collection activities.**
4. **We may contact you at your home or via other contact information you provided us with to confirm your appointment or discuss treatment related information with you.**

* **The practice may condition rendering of treatment upon the execution of this consent.**

SIGNATURE: _____ **DATE:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following…

Personal Representative's Name: _____

Relationship to Patient: _____

RECORDS RELEASE AUTHORIZATION

TO: _____

I hereby authorize and request you to release to:

Dr. Vincent Cardinale
Riverchase Commons
1019 Crosspointe Drive Suite #2
Naples, FL 34110

Telephone: 239-596-9868
Fax: 239-597-9782

Email: Angie@cardinaledentistry.com

My complete history records and any x-rays in your possession concerning my past dental treatment, including present treatment.

NAME:_____

ADDRESS:_____

_____

Signature:_____ Date:_____