PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT) Home Phone (________) __________ - ____________

Cell Phone (________) __________ - ____________

Patient ____ ______________ ____

First Name Middle Initial Last Name

Address ___________________________________ Apt #________ City __________________________ State _______ Zip __________

Sex M _____ F _______ Age ________ Birth Date _______________ Single _________ Married ________

Email Address: ____

Employer ______________________________ Occupation ___________________ Business Phone (________) _________ - ____________

Business Address ____ Social Security __________ - __________ -__________

Name of Primary Dental Insurance Company ____

Group Number ______________________________________ Identification Number _______________________________________

Guarantor of Account & date of birth________________________________ ___/___/___ Relationship to Patient ____________________

Guarantor's Social Security __________ - __________ -__________ Guarantor's Business Phone (________) _________ - ____________

Name of Secondary Dental Insurance Company ____

Group Number ______________________________________ Identification Number _______________________________________

Guarantor of Account & date of birth________________________________ ___/___/___ Relationship to Patient ____________________

Guarantor's Social Security __________ - __________ -__________ Guarantor's Business Phone (________) _________ - ____________

In case of emergency, who should be notified?________________________ Relationship to Patient _____________

Phone (________) _________ - ____________

Whom may we thank for referring you? ____

If any, list medications currently being taken 1)______________________ 2)___________________ 3) ___________________

4) ___________________ 5) ____________________ 6) ____________________

Do you have or have you ever had any of the following? (Check all that apply):

Rheumatic Fever _____
Mitral Valve Prolapse _____
Heart Murmur _____
High Blood Pressure _____
Cancer ___
Radiation Treatment _____
Ulcer _____
Allergic to Penicillin _____

Artificial Heart Valves _____
Artificial Hip, Knee or Joints ___
Sinus Problems _____
Psychiatric Care _____
Blood Disease _____
Hepatitis _____
Pacemaker _____

Liver Disease ___
HIV/AIDS _____
Stroke _____
Diabetes _____
Respiratory Disease _____
Epilepsy ___
Allergies to Medicine/Antibiotics _____
Stomach Problems ______

Have you ever had any adverse reaction to any medication? **Y** **N**

If yes, what ____

Have you ever responded negatively to medical or dental treatment? **Y** **N**

If Yes, explain ____

Do you suspect that you are pregnant? **Y** **N** Are you nursing? **Y** **N**

Is there anything else we should know about your medical history? ____

____

The above information is accurate and complete to the best of my knowledge.

Signature of Patient or Legal Guardian if Minor ____ Date ________________

CAMBRIA FAMILY DENTAL CENTER
Richard S. Seaman, D.D.S
228-02 Linden Boulevard, Cambria Heights, NY 11411
(718) 528-8592

OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We are committed to providing you with the best dental care possible at an affordable cost. The following is a statement of our Financial Policy which we require you to read and sign prior to start of treatment.

All patients must complete our Patient Registration Form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, CHECKS, AND CREDIT CARDS PLUS WE OFFER EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPROVAL

Regarding Insurance

In order for us to receive payment from your insurance company you must provide us with accurate up to date and complete information of all dental insurances you may be covered by; this includes coverage under your primary carrier as well as that of your spouse. **Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account balance in full within 45 days, the balance will be automatically billed to your credit or debit on file.** Please speak to our financial secretary for payment arrangements. Please be aware that some or all of the services provided may be non-covered services under your plan and not considered reimbursable by your insurance policy's arbitrary guidelines. **Payment in full is due on date charges are incurred or, in the case of prosthetic services, the day the treatment is completed.**

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for co-payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

In the case of Insurance Plans where we are participating, all **co-payments** and **deductibles** are due in full at time of treatment. We suggest you **bring a benefit booklet** with you that will clarify your dental benefits, which you can obtain from the HR department of your place of employment.

Minor Patients

The adult(s), parent(s), or guardian(s) accompanying the minor are responsible for full payment for the child/ren's treatment(s) the day they are rendered. For un-accompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, major credit card, or payment by cash or check at time of service.

Collection Accounts

Private balances not paid in full within 30, unless payment arrangements approved by our office are in effect, will be turned over to our collection department and a fee of $25.00 will be added to the account balance. Please help us to avoid this action by paying your balance on time.

RETURNED CHECKS

Any personal checks returned to our office from the bank due to insufficient funds, provided the check was deposited on after the date listed will be subject to a $35 fee added to the guarantor's account balance.

MISSED APPOINMTNETS

Unless cancelled at least 24 hours in advance, our policy is to charge $25.00 for each appointment missed. Please help us to serve you better by keeping your scheduled appointment.

Thank you for understanding our Financial Policy. By complying with the aforementioned we can eliminate billing, unnecessary paperwork, costs and maintain our fees at an affordable level. We can also devote more of our time and energy towards making your visits to our facility more pleasant and serving you more efficiently. Please let us know if you have any questions or concerns.

Your signature indicates you have read the Financial Policy and that you understand, agree, and will adhere to its guidelines.

x ____

Signature of Patient (18 years or older) or Responsible Party (if patient is a minor) Date

Dr. Richard Seaman, D.D.S & Associates
228-02 Linden Blvd.
Cambria Heights, NY 11411
Tele: 718 528-8592 Fax: 718 528-9618

Signature on File Agreement

I request that payment of authorized benefits be made on my behalf to Dr. Richard Seaman & Associates for services furnished to me by the provider. I authorize any holder of Dental information about me to release to my Insurance Company any information needed to determine these benefits or the benefits payable for related services.

Your signature below signifies your understanding that your insurance company (private insurance) may not cover the services provided or may not cover them at 100%. You will be responsible for any charges not covered by your insurance policy.

Patient Signature: ______________________________ ***Date:*** _____________