Welcome to Cameo Dental

Patient Registration Form

PATIENT INFORMATION (PLEASE PRINT)

Last Name:	First Name:	MI:	Preferred Name:
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Birthdate:	
Sex*: ☐ M ☐ F ☐ Non-Binary	Email:		
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Separated ☐ Widowed			
Employer:	Work Phone:		

Spouse or Parent's Name:	
Spouse or Parent's Employer:	Work Phone:
Person to Contact in Case of Emergency:	Phone:

Whom May We Thank for Referring You?

RESPONSIBLE PARTY (PLEASE PRINT)

Person Responsible for Account: ☐ Self – see information above (if checked, skip to next section) ☐ Someone Else – (if checked, complete all fields below)			
Responsible Party Name:	Relationship to Patient:		
Street Address:	City:	State:	Zip:
Phone:	Are they currently a patient in our office? ☐ Yes ☐ No		
Employer:	Work Phone:		

INSURANCE INFORMATION (PLEASE PRINT)

Do you have Dental Insurance? ☐ Yes ☐ No If Yes, please fill out the information below. If No, you may skip the remainder of this form.

Dental Insurance Company:	Policyholder:
If **you** are the Policyholder, and you **do not** have an ID# for your insurance policy, please provide your SS# here:	

If Policyholder is someone other than yourself, please fill out their information below:

Policyholder's Address:	City:	State:	Zip:
Policyholder's Phone:	Policyholder's Birthdate:	Policyholder's Employer:	
Policyholder's SS# (only required if you **do not** have an ID# for this policy):			

Please give a copy of your insurance card to Cameo Dental business staff, OR fill in the information below:

Group #	ID#		
Insurance Co. Address:	City:	State:	Zip:

If you carry additional dental insurance policies, please see the back of this form.

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SECONDARY INSURANCE (PLEASE PRINT)

Do you have Secondary Dental Insurance? ☐ Yes ☐ No If Yes, please fill out the information below. If No, you may skip the remainder of this form.

Secondary Dental Insurance Company:	Policyholder:
If **you** are the Policyholder, and you **do not** have an ID# for your insurance policy, please provide your SS# here:	

If Policyholder is someone other than yourself, please fill out their information below:

Policyholder's Address:	City:	State:	Zip:
Policyholder's Phone:	Policyholder's Birthdate:	Policyholder's Employer:	
Policyholder's SS# (only required if you **do not** have an ID# for this policy):			

Please give a copy of your insurance card to Cameo Dental business staff, OR fill in the information below:

Group #	ID#		
Insurance Co. Address:	City:	State:	Zip:

TERTIARY INSURANCE (PLEASE PRINT)

Do you have Tertiary Dental Insurance? ☐ Yes ☐ No If Yes, please fill out the information below. If No, you may skip the remainder of this form.

Tertiary Dental Insurance Company:	Policyholder:
If **you** are the Policyholder, and you **do not** have an ID# for your insurance policy, please provide your SS# here:	

If Policyholder is someone other than yourself, please fill out their information below:

Policyholder's Address:	City:	State:	Zip:
Policyholder's Phone:	Policyholder's Birthdate:	Policyholder's Employer:	
Policyholder's SS# (only required if you **do not** have an ID# for this policy):			

Please give a copy of your insurance card to Cameo Dental business staff, OR fill in the information below:

Group #	ID#		
Insurance Co. Address:	City:	State:	Zip:

Thank you, and welcome to Cameo Dental!

If you have any questions or need any assistance with this form,
please reach out to a Cameo Dental team member.

*We require this field because one of the many ways we use this information is to coordinate benefits with your insurance provider. Please make sure the sex you provide here is the same as what your insurance provider has on file (usually the same as what your HR has on file). Our entire team is committed to making sure every patient feels safe, welcome, and respected.

DENTAL HEALTH HISTORY

Confidential

Last Name:	First Name:	Date of Birth:

The below information is complete and accurate to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.		
PLEASE SIGN →	Signature:	Date:

DENTAL HISTORY (PLEASE PRINT)

Do you have any special dental concerns to share with your provider today?:

_____

How often do you brush? _____ How often do you floss? _____

Check if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Sore Jaw Muscles
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ History of Periodontal (Gum) Treatment
- ☐ Sores or Growths in Your Mouth
- ☐ Major Injury to Face/Jaw/Teeth
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Cold
- ☐ Sensitivity when Biting
- ☐ Sensitivity to Sweets

MEDICAL HISTORY (PLEASE PRINT)

Physician's Name: _____ Date of Last Visit (approx.): _____

Pharmacy Name: _____ Pharmacy Location: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, please describe (also see back of this form for a full review of medical conditions):

_____

MEDICATIONS: Please list any medications you are currently taking, or provide a medication list.

_____

ALLERGIES: Please indicate any allergies here.

- ☐ Amoxicillin/Penicillin
- ☐ Other Antibiotics _____
- ☐ Acetaminophen/Tylenol
- ☐ Aspirin
- ☐ Codeine/Opiates
- ☐ Dyes/Coloring
- ☐ Epinephrine
- ☐ Ibuprofen/NSAIDs
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Other (Please Indicate): _____

****PLEASE FILL OUT AND INITIAL THE BACK OF THIS FORM****

DENTAL HEALTH HISTORY

Confidential

Check the boxes below if you have or have had any of the following:

HEART, CARDIOVASCULAR

- ☐ Artificial Heart Valve
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Congenital Heart Defect
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Pulmonary Embolism/DVT
- ☐ Stroke/TIA
- ☐ Other Heart Condition

RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Cough, Persistent
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Other Respiratory Condition

KIDNEYS, GENITOURINARY

- ☐ Dialysis
- ☐ Kidney Problems
- ☐ Sexually Transmitted Infection
- ☐ Other Genitourinary Condition

HEMATOLOGIC. LYMPHATIC

- ☐ Anemia
- ☐ Bleeding Disorder/Hemophilia
- ☐ Blood Transfusion
- ☐ Sickle Cell Disease
- ☐ Other Hematologic/Lymphatic Condition

MUSCULOSKELETAL

- ☐ Arthritis (Osteoarthritis or Rheumatism)
- ☐ Artificial Joints/Joint Replacement
- ☐ Back Problems
- ☐ Jaw Pain
- ☐ Osteoporosis/Bisphosphonate Treatment
- ☐ Other Musculoskeletal Condition

GASTROINTESTINAL

- ☐ Acid Reflux/GERD
- ☐ Celiac Disease
- ☐ Colitis
- ☐ Gastric Bypass Surgery
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Ulcers (Stomach, Mouth, Other)
- ☐ Other Gastrointestinal Condition

PSYCHIATRIC, NEUROLOGICAL, DEVELOPMENTAL

- ☐ Alzheimer's Disease/Dementia
- ☐ Anxiety
- ☐ Attention Deficit Disorder (ADD/ADHD)
- ☐ Autism
- ☐ Cognitive or Physical Impairment
- ☐ Depression
- ☐ Epilepsy
- ☐ Headaches (Frequent) or Migraine
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Psychiatric Condition
- ☐ Seizures
- ☐ Sensory Processing Disorder/Sensory Issues
- ☐ Tourette Syndrome
- ☐ Other Psychiatric, Neurological, or Developmental Condition

ENDOCRINE

- ☐ Diabetes
- ☐ Hormone Therapy
- ☐ Thyroid Problems
- ☐ Other Endocrine Condition

EYES, EARS, NOSE, MOUTH & THROAT

- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Sinus Problems
- ☐ Tonsillitis
- ☐ Vision Impaired/Blindness
- ☐ Ulcers (Stomach, Mouth, Other)
- ☐ Other Eyes, Ears, Nose, Mouth, or Throat Condition

OTHER

- ☐ Cancer (Chemo, Radiation, Surgery)
- ☐ Chemical Dependency
- ☐ Cold Sores/Fever Blisters
- ☐ Cortisone/Steroid Treatments
- ☐ Cosmetic Surgery
- ☐ Fainting
- ☐ Head and Neck Radiation
- ☐ HIV/AIDS
- ☐ Leukemia
- ☐ Pregnancy/Nursing (Currently)
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Skin Rash
- ☐ Swelling of the Feet or Ankles
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Other Surgical Procedure: _____
- ☐ Other Medical Condition: _____

PLEASE INITIAL AFTER COMPLETING THIS SIDE OF FORM: _____

Acknowledgment and Release

We are pleased that you have selected Cameo Dental to provide your dental services. We aim to provide you with quality comprehensive care.

Please initial each section and sign below to show you have read, understand, and consent to our policies.

____ **Broken Appointment Policy:**

A Broken Appointment is any appointment that is Missed, Canceled, or Rescheduled for any reason with less than 24 hours notice. Our Broken Appointment fee is $50. Once an appointment is made with Cameo Dental, that time is set aside especially for you. It is important for you to keep scheduled dates and time to properly complete your treatment. We make sure that substantial resources are available for each appointment, and, once reserved, an appointment time is unavailable for other patients who need to schedule their care.

____ **Insurance:**

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. As a courtesy, we will prepare and submit forms to assist you in obtaining maximum benefits available. However, the dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires. Your dental benefits are a contract between you, your employer, and the insurance company; therefore, we do not confirm insurance eligibility or predetermine recommended treatment. It is the patient and/or guardian's responsibility to determine eligibility, benefits, and coverage.

____ **Financial Policy:**

We will provide a truthful cost estimate of our services, and you'll be given the opportunity to discuss financial arrangements. You agree to pay the estimated in-network patient responsibility on the day of treatment. You agree to pay in full if not utilizing insurance, if your insurance is out of network, or if a procedure is a non-covered benefit. All patients will be asked to pay their portion at time of service unless other financial arrangements have been established. Balances over 60 days will be charged a finance charge as stated on your bill.

____ **Collection Assignment:**

In the event the balance of your account becomes more than 90 days overdue, billing may be turned over to an outside collection agency. The responsible party listed below agrees to pay interest, collection, and other legal expenses related to the collection of fees owed. Waiver of any breach of time or condition shall not constitute a waiver of any further term or conditions.

____ **Release:**

The above information is accurate and complete to the best of my knowledge. I consent to dental treatment and authorize release of all information necessary to secure benefits. I authorize my insurance company to release payment directly to the dental office for services rendered. **I understand I am financially responsible for all charges whether or not paid by insurance.**

Printed Name: _____ **Signature:** _____ **Date:** _____

CAMEO DENTAL, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us at:

Telephone: (651)423-2259

Address: 14470 Cameo Avenue | PO Box 170
Rosemount, MN 55068

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to us at the address or telephone listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

May we leave a detailed message for you when necessary? (Email, Text, Voicemail) ☐ Yes ☐ No

This Consent also extends to:

_____ _____
(Please print) (Relationship)

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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.