CHERRY BLOSSOM
FAMILY • DENTISTRY

13431 Fishhawk Boulevard, Lithia, FL 33547
(813) 438-5925 phone • (813) 438-5927 fax
info@dentistfishhawk.com email

NEW PATIENT REGISTRATION

Patient Information

Name (Last, First, MI) _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ DOB _____ ❑ Single ❑ Married ❑ Widowed ❑ Seperated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whome may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account (Last, First, MI) _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different than above) _____

Home Phone _____ Cell Phone _____

Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract# _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient coverfed by additional insurance? ❑ Yes ❑ No Subscriber Name _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different than above) _____

Home Phone _____ Cell Phone _____ Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract# _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

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Patient's Name: _____

DENTAL HISTORY

Please check any of the following problems that apply to you.	Yes	No
Sensitivity (hot, cold, sweet, pressure) -Where? UR UL LR LL	❑	❑
Headaches, earaches, neck pain	❑	❑
Jaw Joint Pain	❑	❑
Teeth or Fillings Breaking	❑	❑
Grinding or Clenching Teeth	❑	❑
Bleeding, Swollen or Irritated Gums	❑	❑
Have you had periodontal (gum)	❑	❑
treatments?	❑	❑
Loose, tipped or shifting teeth	❑	❑
Bad breath	❑	❑
Approximately when was your last dental cleaning? _____ Date:		

Do you have or have you had any of the following?	Yes	No
Dentures	❑	❑
Partial Dentures	❑	❑
Braces	❑	❑
Periodontal (gum) treatments	❑	❑
I would like to include in my treatment plan:		
Teeth Whitening	❑	❑
Straighter Teeth	❑	❑
Dental Implants	❑	❑
Replace Missing Teeth	❑	❑

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Conditions/Surgery	❑	❑	Cortisone	❑	❑	High Blood Pressure	❑	❑	Rheumatic Fever	❑	❑
Artificial Joints	❑	❑	Medication	❑	❑	HPV	❑	❑	Rheumatism	❑	❑
AIDS/HIV	❑	❑	Diabetes	❑	❑	Jaundice	❑	❑	Scarlet Fever	❑	❑
Allergies (Seasonal)	❑	❑	Dizziness	❑	❑	Kidney Disease	❑	❑	Seizures	❑	❑
Anemia	❑	❑	Drug Addiction	❑	❑	Liver Disease	❑	❑	Sinus Problems	❑	❑
Angina (Chest Pain)	❑	❑	Emphysema	❑	❑	Low Blood Pressure	❑	❑	Sleep Apnea	❑	❑
Arthritis	❑	❑	Epilepsy	❑	❑	Nervousness/Depression	❑	❑	Stomach Problems	❑	❑
Asthma	❑	❑	Excessive Bleeding	❑	❑	Pacemaker	❑	❑	Thyroid Disease	❑	❑
Blood Disease	❑	❑	Fainting	❑	❑	Pregnant Currently	❑	❑	Tuberculosis	❑	❑
Bruise Easily	❑	❑	Hepatitis A	❑	❑	Radiation (Head/Neck)	❑	❑	Ulcers	❑	❑
Cancer	❑	❑	Hepatitis B	❑	❑	Respiratory Problems	❑	❑	Other:_____	❑	❑
Cervical Cancer	❑	❑	Hepatitis C	❑	❑	Glaucoma	❑	❑			
High Cholesterol	❑	❑									

Are you allergic or have you reacted adversely to any of the following medications?

	Yes	No		Yes	No
Aspirin	❑	❑	Hydrocodone	❑	❑
Latex	❑	❑	Oxycodone	❑	❑
Local Anesthetic	❑	❑	Erythromycin	❑	❑
Tetracycline	❑	❑	Penicillin	❑	❑
Codeine	❑	❑	Sulfa	❑	❑

Have you ever taken any of the following?

	Yes	No
Actonel	❑	❑
Aredia	❑	❑
Fosamax	❑	❑
Reclast	❑	❑
Zometa	❑	❑
Boniva	❑	❑

Are you under a physician's care? ❑Yes ❑No
What for? _____

What medications are you currently taking?_____

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

_____ _____ _____

Patient Signature (Parent of Child) Date Dentist Signature

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Patient Name _____

ANTIBIOTIC PRE-MED FORM

The recommendations for pre-med have changed within the last several years. Please check any that applies to you.

Please check any/all that apply:	Yes	No
Prosthetic heart valves, including transcatheter-implanted prostheses and homografts.	❑	❑
Prosthetic material used for cardiac valve repair, such as annuloplasty rings and chords.	❑	❑
A history of infective endocarditis;	❑	❑
A heart transplant with valve regurgitation due to a structurally abnormal valve.	❑	❑
Unrepaired cyanotic congenital heart disease, including palliative shunts and conduits.	❑	❑
Any repaired congenital heart defect with residual shunts or valvular regurgitation at the site of or adjacent to the site of a prosthetic patch or a prosthetic device.	❑	❑

Please check any/all that apply for children:	Yes	No
Cyanotic congenital heart disease (birth defects with oxygen levels lower than normal), that has not been fully repaired, including children who have had a surgical shunts and conduits.	❑	❑
A congenital heart defect that's been completely repaired with prosthetic material or a device for the first six months after the repair procedure.	❑	❑
Repaired congenital heart disease with residual defects, such as persisting leaks or abnormal flow at or adjacent to a prosthetic patch or prosthetic device.	❑	❑

❑ **I have a heart condition or have had heart surgery, but I am unsure what was done.**

❑ **I have had a heart surgery/condition but it was none of the listed procedures/problems**
- **Please list the surgery/condition: _____**

❑ **I have no heart conditions/surgeries**

_____ _____ _____
Patient Signature (Parent of Child) Date Dentist Signature

* https://www.ada.org/resources/ada-library/oral-health-topics/antibiotic-prophylaxis

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FINANCIAL FORM

Patient Name _____ Date _____

Cherry Blossom Family Dentistry is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

Initial

_____ ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL

_____ FULL PAYMENT IS DUE AT TIME OF SERVICE

_____ WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS

_____ CBFD PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICES ARE ESTIMATED AND DUE AT THE TIME OF SERVICE.

_____ WE DO OUR BEST TO ESTIMATE WHAT BENEFITS YOUR INSURANCE WILL PAY. WE ARE NOT A PART OF YOUR DENTAL CONTRACT THAT YOU HAVE WITH YOUR DENTAL INSURANCE CARRIER. WE RECEIVE VERY LIMITED INFORMATION WHEN WE VERIFY YOUR BENEFITS

_____ MINORS ACCOMPANIED BY AN ADULT
The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

_____ INSURANCE
CBFD provides insurance company billing for our patients. The patient portion of particular dental services are estimated and due at time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by CBFD staff regarding his/her remaining benefit in any such benefit period.

_____ The claims we submit to insurance companies indicate that you have assigned those benefits to CBFD. However, if you are paid by the insurance company instead of CBFD, you then become responsible for the total account balance and payment would be expected immediately.

_____ If you or your family have more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You, as a patient, are always responsible for any changes that are not covered by your insurance.

_____ DELINQUENT PAYMENTS
It is our policy to charge finance fees of 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

_____ MISSED APPOINTMENTS
Unless canceled 48 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per each 30 minutes of missed appointment time. After missing one scheduled appointment, you will be responsible for pre-paying future appointments to reserve that appointment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____ Date _____

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PATIENT/RELATIVE HIPAA CONSENT

Patient Name _____

Address _____

Telephone _____

Email _____

Patient DOB _____

I, _____, understand that by signing this Consent form, I am giving my consent to Cherry Blossom Family Dentistry to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name _____

Relationship _____

I understand that I have the right to revoke this consent at any time by giving written notice to Cherry Blossom Family Dentistry of my revocation to the following:

Cherry Blossom Family Dentistry Human Resources Department
13431 Fishhawk Boulevard, Lithia, FL 33547
(813) 438-5925 phone • (813) 438-5927 fax
info@dentistfishhawk.com email

_____ _____
Patient's Signature (Legal Guardian, if Patient is a minor) Date

_____ _____
Witness Date