CityLine Dental Center

1415 E. Renner Rd. | Suite #250 • Richardson, TX 75082 (972)231-9499

Welcome to Cityline Dental Center

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

How did you first hear about our office? _____

What is your immediate concern?

_____

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Referral Name: _____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Dental Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Insurance Company Phone Number: _____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Secondary insurance company phone number: _____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

NAME:_____ DATE:_____

MEDICAL HISTORY 2026

Please circle **yes** or **no** for any of the following problems/conditions that apply to you:

AIDS	Y N	Dizziness	Y N	HIV Positive	Y N	Scarlet Fever	Y N
Allergies (Seasonal)	Y N	Drug Addiction	Y N	HPV (Human Papilloma Virus)	Y N	Seizures	Y N
Anemia	Y N	Emphysema	Y N	Jaundice	Y N	Sinus Problems	Y N
Angina (chest pain)	Y N	Epilepsy	Y N	Jaw Joint Pain	Y N	Sleep Apnea	Y N
Arthritis	Y N	Excessive Bleeding	Y N	Kidney Disease	Y N	Stomach Problems	Y N
Artificial Heart Valve	Y N	Fainting	Y N	Liver Disease	Y N	Stroke	Y N
Artificial Joints	Y N	Glaucoma	Y N	Low Blood Pressure	Y N	Thyroid Disease	Y N
Asthma	Y N	Heart Conditions	Y N	Mitral Valve Prolapse	Y N	Tuberculosis	Y N
Blood Disease	Y N	Heart Lesions (congenital)	Y N	Nervousness/Depression	Y N	Ulcers	Y N
Bruise Easily	Y N	Heart Murmur	Y N	Pacemaker	Y N	Venereal Disease	Y N
Cancer	Y N	Heart Surgery	Y N	Pregnant Currently	Y N	Other:	
Cervical Caner	Y N	Hepatitis A	Y N	Radiation (head/neck)	Y N		
Chemotherapy	Y N	Hepatitis B	Y N	Respiratory Problems	Y N		
Cortisone Medication	Y N	Hepatitis C	Y N	Rheumatic Fever	Y N		
Diabetes	Y N	High Blood Pressure	Y N	Rheumatism	Y N		

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

Aspirin	Y N	Percodan	Y N	Tetracycline	Y N	Valium	Y N
Darvon	Y N	Latex	Y N	Codeine	Y N	Penicillin	Y N
Nitrous Oxide	Y N	Local Anesthetic	Y N	Erythromycin	Y N	Sulfa	Y N

Other:

Have you ever taken any of the following medications?

Actonel	Y N	Aredia	Y N	Boniva	Y N	Fosamax	Y N
Reciast	Y N	Zometa	Y N	Blood Thinner	Y N	Herbal Supplements	Y N

Please list all the medications your are currently taking:_____

Do you have other healthcare providers besides your PCP, cardiologist or pulmonologist? Examples are ENT, endocrinologist, chiropractor, etc.? Y N

Please list:

Name:_____ Specialty:_____

Name:_____ Specialty:_____

By providing this information, you allow us to contact your physician(s) should we have any questions or concerns about your health that may be associated with your medical care.

_____ _____

Address Phone Number

_____ _____ _____

Print Patient Name Signature of patient, parent or guardian Date

Dental Health History

Please check any of the following that apply to you:

- ☐ Smoke, vape, or use chewing tobacco
- ☐ Had trouble getting numb
- ☐ Any teeth sensitive to hot, cold, or pressure (biting), sweets
- ☐ Bleeding, swollen or irritated gums
- ☐ Dry mouth or constantly thirsty
- ☐ Have any teeth became loose on their own (without injury)
- ☐ Catch food between teeth
- ☐ Had complications from past dental treatment
- ☐ Had any reaction to local anesthethic
- ☐ Avoid brushing any part of your mouth
- ☐ Noticed any unpleasant taste or odor in your mouth
- ☐ Experience gum recession
- ☐ Missing or spaces between teeth
- ☐ Dissatisfied with the appearance of your teeth

Do you have, or have had any of the following?

- ☐ Dentures or Partials
- ☐ Periodontal Disease or Gum Treatment
- ☐ Fear or Anxiety About Dental Treatment
- ☐ Wear or have worn a bite appliance or nightguard
- ☐ Braces
- ☐ Jaw Surgery
- ☐ Whitened or bleached your teeth

If I could change my smile, I would:

☐ Make My Teeth Whiter ☐ Make My Teeth Straighter ☐ Close Spaces or Gaps ☐ Replace Dark Metal Fillings ☐ Replace Missing Teeth
☐ Replace Old Crowns ☐ Have a Smile Makeover

On a scale from 1-10, with 10 being the highest rating:

How important is your dental health to you? *

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Where would you rate your current dental health? *

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Where would like your dental health to be? *

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Previous Dentist Name and Phone Number:

_____

_____

I routinely see my dentist every:

◯ 3 mo. ◯ 4 mo. ◯ 6 mo. ◯ 12 mo. ◯ Not routinely

Date of your last dental exam and x-rays: _____

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

When was your last oral cancer screening? _____

Consent for Services and Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality of dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and American Express. Outside financing is available upon request and approval.

Please Note: Returned checks will be subject to additional fee of $35.00. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance you will be responsible for any collection and/or legal fees incurred.

A parent or legal guardian must accompany minors to their dental visits.
The parent or guardian who brings the child to the dental visit is responsible for payment, independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

☐ *By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration.

Dental Insurance

As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, HOWEVER IT IS NOT A GUARANTEE THAT YOUR INSURANCE COMPANY WILL PAY EXACTLY AS ESTIMATED. Your insurance company and your plan benefits ultimately determine the amount paid. We will of course do all we can to make sure your estimate is as accurate as possible.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

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 payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Please sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

We require payment for the deductible and any co-payment, which is the estimated amount not covered by your insurance. A down-payment is required prior to scheduling dental treatment. This will be discussed on an individual basis with our financial coordinator during your consultation.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to ensure payment. If payment is not received within 90 days you will be responsible for payment in full regardless of the claim status.
If your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, our office will not enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

OFFICE APPOINTMENT POLICY

All appointments are your responsibility. As a courtesy we will send reminders regarding your appointment. We ask you to confirm your appointment through phone, email or text. We require a 48 hour notice if you need to reschedule your appointment. If we do not receive a notice our office charges a fee in the amount of $35.00/$50.00 for each missed or no-showed appointment.

☐ *By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration.

Informed Consent For Notice Of Privacy Practices

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law, You agree that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor the agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

* ◯ Yes ◯ No

May we leave a message at home or on cell?

* ◯ Yes ◯ No

May we discuss your dental condition/ treatment with any member of your family?

* ◯ Yes ◯ No

If yes, please name the family members below:

_____

_____

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Consents.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account, appointment and clinical information) to the secured web site for the dental practice. I understand for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and

use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ *I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

Response Date: _____

CityLine Dental Center

1415 E. Renner Rd. | Suite #250 • Richardson, TX 75082 (972)231-9499

CityLine Dental Center
Oral Cancer Screening Consent Form

In our continuing effort to provide the most advanced technology and highest standard of care available to our patients, this practice includes the Identafi Oral Cancer detection system as an integral part of your annual oral exam. Identafi uses various wavelengths of light known as fluorescence and reflectance technology to aid our office seeing oral abnormalities that are or could become cancer. As always, we will visually screen you for oral cancer, but the Identafi greatly enhances our ability to find signs of cancer and dysplasia earlier than possible with our eyes alone.

One person dies every hour from oral cancer in the United States, and the mortality had remained unchanged for more than 40 years. Late detection of oral cancer is the primary contributing factor to this alarming statistic. As with most other cancers, early detection is very important. Although age, tobacco and alcohol use increase the probability of oral cancer, 25% of oral cancer victims have no lifestyle risk factors. According to the American Cancer Society, more women in the United States will be diagnosed with oral cancer this year than will be diagnosed with cervical cancer. Furthermore, there are as many cases of oral cancer caused by the Human Papilloma Virus (HPV), a sexually transmitted disease, as there are HPV related cases of cervical cancer.

Due to the increased prevalence of HPV, this oral cancer screening is recommended annually for everyone age 18 and over. Conducting an oral cancer screening with Identafi improves our ability to identify and evaluate suspicious areas at their earliest stages. Early detection of pre-cancerous lesions can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. Proven screening technologies such as mammogram, Pap smear and colonoscopy are routinely utilized to detect cancer in its early stages. An oral cancer screening with the Identafi is easy and painless, and gives this practice the best chance to find any abnormalities you may have at the earliest possible stage.

Although oral cancer screenings are encouraged by the American Dental Association and an insurance code exists for billing. This enhanced exam with the Identafi may not be covered by your insurance. The fee for this procedure is $45.00.

I authorize CityLine Dental Center to perform an oral cancer screening using the Identafi. I realize that no screening result can't guarantee that oral cancer will never occur. Furthermore, I understand that if areas of suspicion are detected, referrals and diagnostic tests may be needed to confirm or dismiss the presence of oral cancer. *

◯ Yes ◯ No

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

Signature _____ **Date** _____

Response Date: _____