WELCOME TO OUR OFFICE

- **Whom may we thank for referring you to our practice?**

___ Internet ___ Postcard ___ Newspaper ___ Another Patient: _____

PATIENT INFORMATION

Patient Name: _____ Date: _____
First Last (Preferred Name)

SSN: xxx-xx-_____ DOB: _____ Male / Female Marital Status: _____
(Circle One)

Phone (H): _____ Cell Phone: _____ Ok to leave message? Y/N

Emergency Contact: _____ _____ Relationship :_____
(Name) (Phone #)

Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION (if other than patient)

Name: _____ DOB: _____ Male/Female
(circle one)

SSN: xxx-xx-_____ Phone: _____ Best time to call: _____

Address: _____ City: _____ State: _____ Zip: _____

DENTAL INSURANCE INFORMATION

Subscriber Name: _____ Relationship to patient: _____

Subscriber DOB: _____ ID #: _____ Group #: _____

Insurance Carrier: _____ Phone: _____

Ins Address: _____City: _____ State: _____ Zip: _____

FINANCIAL AGREEMENT

In order to avoid any misunderstanding regarding our financial policy, it is necessary for you to read and sign this document before treatment.

DENTAL INSURANCE: As a courtesy, we will gladly file your claims provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract.
- If we are not a preferred provider of your insurance you are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" fees. We will be happy to provide a dental claim to expedite your reimbursement.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Receiving our services indicates your acceptance of responsibility to pay regardless of your estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. If your insurance fails to pay within 60 days, you will be responsible for the balance on your account.
- Not all the services we provide are covered benefits. Benefits differ by plan. Fees for non-covered services along with deductibles and copayments are due at time of service.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

PAYMENT POLICY: We accept cash, personal checks and credit cards. If a check is used it must be the patient's account and signed by the patient. Third party checks are not accepted.

RETURNED CHECKS: A $75.00 charge will be applied when a check is returned by the bank. Non-payment checks not reconciled will be sent to the State Attorney's office.

CANCELLATION POLICY: A fee of $100.00 will be applied if an appointment is cancelled or broken without a **24 hour notice**. We reserve the right not to make future appointments if this occurs more than twice. This fee is subject to change without notice.

RECORD COPIES: A nominal fee (as noted by the Florida Dental Practice Act) of $20.00 for copies of all radiographs and $10.00 for the first 10 pages of clinical notes is due. Our office has 30 days to release all necessary information.

I have read, understand and agree to this financial policy.

_____

(Patient signature) (Printed name) (Date)

_____

(Responsible party signature) (Printed name) (Date)

CONSENT FOR SERVICES

Patients who carry dental insurance that our office is not contracted with, understand that all dental services rendered are charged directly to the patient and that he or she is personally responsible for payment on all dental services. This office will help prepare the patients' insurance forms. However, this dental office cannot render services on the assumptions that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the cost of services at the time rendered.

I grant my permission to you or your assignee; to telephone me at home or at my work to discuss matters related to this form. (Please check mark the following):

Telephone me at:

1. Home _____
2. Cell Phone _____
3. Work _____

Write me via:

1. Cell Phone Text Message _____
2. Email _____

I give permission to leave voice messages: (Please check mark the following):

1. Cell Phone Message _____
2. Home Phone Message _____

I have read the above conditions of treatment and payment and agree to their content.

I have read and understand the "Notice of Privacy Practice for Protected Health Information" document. If desired I understand that I can have a copy for my records.

Name:_____ **Date**: _____

(SIGNATURE OF PATIENT OR GUARDIAN/ RESPONSIBLE PARTY)

Name:_____

HEALTH INFORMATION

Date of last dental visit: _____ Reason for this visit: _____

Name, and phone # of physician:

_____

Have you ever had or have any of the following? Please check those that apply:

___ Arthritis	___ Head Injuries	___ Respiratory Problems
___ Asthma	___ Heart Murmur	___ Rheumatic Fever
___ Blood Disease	___ High Blood Pressure	___ Rheumatism
___ Diabetes	___ High Cholesterol	___ Sinus Problems
___ Dizziness	___ Jaundice	___ Stomach Problems
___ Drug/ Alcohol Problems	___ Kidney Disease	___ Stroke
___ Epilepsy	___ Mental Disorders	___ Thyroid
___ Fainting	___ Mitral Valve Prolapse	___ Tuberculosis
___ Glaucoma	___ Nervous Disorders	___ Ulcers
___ Hay Fever	___ Pace Maker	___ Smoker/Tobacco User

• Do you have Hepatitis, AIDS, HIV, or a ventral disease? _____ If yes, please describe and provide current status _____

• For females: Are you currently pregnant? _____ If yes, due date? _____

• Have you ever, or do you currently take illegal drugs? _____ If yes, please describe

_____

• Have you ever, or do you now have alcohol problems? _____ If yes, please describe

_____

• List **all** medications you are now taking daily:

_____

• Have you ever had an allergic reaction to medication? _____ If yes, please describe

_____

Name:_____

Have You Ever Had or Been Treated For:

- Rheumatic fever, Rheumatic Heart Disease, Heart murmur or congenital heart disease? **Y / N**
- Heart trouble, heart attack, angina, heart surgery, a pacemaker or irregular heart beat? **Y / N**
- Stomach or intestinal disease? **Y / N**
- Abnormal blood pressure, excessive bleeding or anemia? **Y / N**
- Cancer, x-ray treatments, chemotherapy, or IV bisphosphonate treatment? _____ If yes, please describe

  _____
- Have you ever had a major operation? _____ If yes, please describe

  _____
- **Females**: Are you currently taking any bisphosphonate medication? **Y / N**
- Have you had any prosthetic joint replacement? **Y /N** If yes, please describe:

  _____
- Have you ever been told to take antibiotics prior to dental treatment? **Y / N**

  _____

DENTAL HISTORY

1. Chief dental complaint if any? _____
2. Name of previous dentist _____
3. Do you have any of your x-rays or records? _____

In respect to any previous dental treatment have you:

- Had complications during or following treatment? _____ If yes, please describe

  _____
- Do your gums bleed on brushing or eating? **Y / N**
- Do you grind your teeth or clench your jaws? **Y / N**
- Does food catch between your teeth? **Y / N**
- Do any of your teeth ache? **Y/ N**
- Are any of your teeth sensitive to heat, cold or pressure? **Y / N**
- Do you have pain or clicking in the jaw? **Y / N**
- Have your jaw muscles ever been sore? **Y / N**
- Do you like your smile? **Y / N**