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 dental plan. Fees for non-covered services along with deductibles and copayments are due at the 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 be 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 at 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

2. Do you like your smile? ___ Yes ___ No
   Please Explain:

   ____

3. Do dental visits make you anxious? ___Yes ___No
   Please Explain:

   ____

4. Have you been admitted to the hospital or needed emergency care during the past two years?
   ___Yes ___No
   If yes, Please Explain:

   ____

5. Are you now under the care of a physician? ___Yes ____ No
   If Yes, please explain: ____
   Name of Physician: ____

6. Have you ever had any complications following dental treatment? ___Yes ___No
   If Yes, please explain:

   ____

UPDATED PATIENT INFORMATION

Patient Name: ____ Date: ______________
Last, First, MI(Preferred Name)

Social Security #: ______________________________________ Birth Date: ________________

_____Male ____Female _____Married _____ Single _____ Child Other: _______________________

Phone (H): ___________________________ Cell: ___________________________________

Is it Ok to leave message? _________ Email: ____

Address: ____
Street Apt#

____
City State Zip Code

Are you a Seasonal Resident? ____________ If so, when do you reside in Florida? _________________

Emergency Name: ____________________________ Phone #:____________________________

HEALTH INFORMATION

Date of last dental visit: _______________ Reason for Visit: ________________________________

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

___ AIDS
___ Anemia
___ Arthritis
___ Artificial Joints
___ Asthma
___Blood Disease
___ Cancer
___ Diabetes
___ Dizziness
___Drug/Alcohol Problems
___ Epilepsy
___ Excessive Bleeding
___ Fainting
___ Glaucoma
___ Growths
___ Hay Fever
___Head Injuries
___ Heart Murmur
___ Hepatitis
___ High Blood Pressure
___ High Cholesterol
___ HIV
___ Jaundice
___ Kidney Disease
___ Mental Disorders
___ Mitral Valve Prolapse
___ Nervous Disorders
___ Pace Maker
___ Pregnancy
Due Date: __________
___ Radiation Therapy
___ Respiratory Problems
___ Rheumatic Fever
___Rheumatism
___ Sinus Problems
___ Stomach Problems
___ Stroke
___ Thyroid
___ Tuberculosis
___ Tumors
___ Ulcers
___ Venereal Disease
___ Smoker
_____ Per Day
___ Tobacco Chewer
___ OTHER:
____
____

Do you have any allergies to medications?
___ Codeine Allergy ___ Penicillin Allergy ___ Latex Allergy ___ Other: ____________________

1. Are you currently taking any medications? ___ Yes ___ No
   If Yes, Please List:
   ____