

Entered by: _____

Patient Information

Last Name _____ First _____ Middle _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work _____
Date of Birth _____ Sex: M or F Social Security Number _____
Occupation _____ Employer _____
Drivers License Number _____ State _____
Marital Status: Single Married Divorced Widowed Minor
Email Address _____ Can you receive texts on cell number? Y or N

Fill this section out if patient is a minor.

Billing Information: Information of the person bringing child to the appointment.

Parent or Guardian Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Date of Birth _____ Social Security Number _____

Insurance Information: Policy Holder

Primary

Policy Holders Name _____ Relationship to Patient _____
Date of Birth _____ Social Security Number _____ Sex M or F
Insurance Company Name _____ Phone Number _____
Employer _____ ID Number _____ Group Number _____

Secondary

Policy Holders Name _____ Relationship to Patient _____
Date of Birth _____ Social Security Number _____ Sex M or F
Insurance Company Name _____ Phone Number _____
Employer _____ ID Number _____ Group Number _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO AND HERBY AUTHORIZE PAYMENT
TO BE MADE DIRECTLY TO DAVID & ASSOCIATES DENTISTRY FROM MY INSURANCE COMPANY.

Signature _____ Signature of Insured _____

Who may we contact in case of emergency? _____ () _____
Physician's Name and Phone Number _____ () _____

HOW DID YOU HEAR ABOUT DAVID & ASSOCIATES

____ Referred by a patient. Name _____ Television What Channel _____
____ Referred by an employee. Name _____ Radio What Station _____
____ Direct Mail. What type _____ Internet _____
____ Brochure _____ Yellow Pages _____
____ Newspaper _____ Other _____

Patient Medical History

Patient Name _____ Date of Birth _____
Today's Date _____ Sex: M or F Height _____ Weight _____

Please provide the name, address, and phone number of your primary care doctor.

Name _____ Phone Number _____
Address _____ City _____ State _____ Zip _____

For the following questions, please circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health? Y or N
Have there been any changes in your health in the last year? Y or N
Have you had a physical examination in the last year? If yes, Date _____ Y or N
Are you currently under the care of a physician? Y or N
if so, what is your condition being treated? _____ Y or N
Have you had any serious illness, operation or hospitalization with in the last 5 yrs? Y or N
Are you currently taking any medications including over the counter or vitamins? Y or N
if so please list: _____

Do you have or have you had any of the following diseases or health problems?

a) Damaged heart valves, artificial valves or heart murmur? Y or N
b) Rheumatic Heart Disease Y or N
c) Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis
or any other heart condition _____ Y or N
1) Do you experience chest pain upon exertion? Y or N
2) Do you experience shortness of breath after mild exercise? Y or N
3) Do your ankles swell? Y or N
d) Do you have any allergies other than medications? If so please list _____ Y or N

e) Sinus trouble Y or N
f) Asthma or Hay Fever Y or N
g) Fainting, Dizzy Spells or Seizures Y or N
h) Diabetes Y or N
i) Hepatitis, jaundice, or liver disease Y or N
j) Frequent or recurring mouth sores Y or N
k) Thyroid problems Y or N
l) Respiratory problems, emphysema, bronchitis, etc Y or N
m) Arthritis or painful, swollen joints, including jaw joint (TMJ) Y or N
n) Stomach Ulcers Y or N
o) Hyperactivity Y or N
p) Kidney trouble Y or N
q) Tuberculosis Y or N
r) Persistent Cough or cough that produces blood Y or N
s) Persistent swollen neck glands Y or N

t) Low blood pressure	Y or N
u) Do you currently have, or have you ever had Cancer or Leukemia?	Y or N
if so, when _____ what type _____	
Name of treating physician _____	Y or N
w) Any disease, drug or transplant operation that has depressed your immune system?	Y or N
Do you have abnormal bleeding?	Y or N
a) Have you ever had a blood transfusion?	Y or N
Do you have a blood disorder, such as anemia?	Y or N
Have you ever had treatment for a tumor or growth?	Y or N
<u>Are you allergic to or have you had any type of reaction to:</u>	
a) Local anesthesia	Y or N
b) Penicillin or other antibiotics Please list _____	Y or N
c) Sulfa Drugs	Y or N
d) Barbiturates or sleeping pills	Y or N
e) Aspirin	Y or N
f) Iodine	Y or N
g) Codeine or any other narcotics	Y or N
h) Latex	Y or N
i) Other please list _____	Y or N
Are you now taking any bisphosphonates, sometimes known by the brand names:	
a) Aredia b) Actonel c) Boniva d) Didronel e) Fosomax f) Reclast g) Seklic h) Zometa	Y or N
Please list name of prescribing physician _____	
Do you have or have you ever been treated for osteoporosis?	Y or N
if yes when? _____ Name of physician _____	
Have you ever been diagnosed with Padgett's disease of the bone?	Y or N
if yes when? _____ Name of physician _____	
Have you had any serious trouble with dental treatment before?	Y or N
if yes when? _____	
Have you ever been advised to take antibiotics prior to dental treatment?	Y or N
if yes when and by whom? _____	
Do you have any other condition or disease not listed above that you feel your dentist would need to know? If yes, please explain _____	Y or N

Are you wearing contact lenses?	Y or N
Are you wearing and removable dental appliances?	Y or N
Do you wish to speak with the dentist privately about any matter?	Y or N
 This section pertains to women only	
Are you pregnant or trying to get pregnant?	Y or N
Do you have problems associated with your menstrual cycle?	Y or N
Are you nursing?	Y or N
Are you currently taking birth control?	Y or N

What is your chief dental complaint? _____

Please list current medications (or attach a list) _____

Certification

I certify that I have read and completed the information requested on the patient medical history for to the best of my knowledge. I acknowledge that my care and treatment will be provided based on my health and dental status as I have indicated on my medical history form. I further certify that I have had an opportunity to ask any questions that I have had and they were answered to my satisfaction. I also certify that by signing this document, I agree not to hold my dentist and any member of the dental staff harmless for any errors or omissions that I have made in the completion of this form, or for any information requested of me that I did not provide verbally or In writing to my dentist that may impact the out come of my dental care and treatment.

Print Name: _____

Signature: _____ Date: _____

TO BE COMPLETED BY THE DOCTOR:

Comments: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Does patient need a medical clearance prior to treatment: Y or N

Does the patient require pre-med before treatment: Y or N

Is patient taking blood thinners: Y or N

Date: _____ Doctor's Signature _____

Payment Policy

Thank you for choosing David and Associates as your primary dental care provider. We are committed to providing you with quality and affordable dental care. If you help us keep our overhead and collections cost down, we can keep providing you with affordable dentistry. Below you will find our payment policy. **Please read and initial in the designated area and then sign and print your name at the bottom of the page.**

Insurance

We accept all **PPO Dental Insurance Policies** and are **In Network** with **Delta Dental** and **Unnoted Concordia ONLY**. We **DO NOT** accept DMO or HMO policies. If we do not accept your insurance plan, payment is expected in full at the time of service. If we do, then your estimated out of pocket expense is expected at the time of services. I agree not to hold David and Associates responsible for knowing what my insurance company pay or will allow for any procedure. _____ **Initial**

Proof of Insurance

I understand that I am responsible for giving my current insurance information to David and Associates on or before the day of services. This will be completed by providing the new information for insurance and any updates in address, phone number or other pertinent information. If I fail to do this I understand that the balance becomes my immediate responsibility. _____ **Initial**

Claims Submission

I understand that David and Associates will allow my insurance company 30 days (the time allowed by the insurance commissioner in the State of Florida) in which to pay or deny my claim. When requested I agree to provide any necessary information to my insurance company in order to process my claim in a timely manner. _____ **Initial**

I understand that my insurance company may fail to pay in accordance with my treatment plan estimate and payment becomes my responsibility. If I have questions regarding why my insurance did not pay as expected, I understand that it is my responsibility to contact my insurance company. Please remember that your insurance contract is between you and your insurance carrier; we are not party to that contract and we are not responsible for knowing the guidelines of that contract. _____ **Initial**

Co-Payments and Deductibles

I understand that I am responsible for my co-payments and deductibles on the day services are rendered. In addition, I understand that it is only an **estimate** and I may owe additional fees to David and Associates after payment is made by my insurance company. _____ **Initial**

Deposits

I understand that when making a reservation for a time on the schedule for a fee of \$500 or more, it is David and Associates policy that a deposit of at least half of the out of pocket be collected at the time the appointment is scheduled, and that I will pay the remaining on the day of services. _____ **Initial**

Balances and Unpaid Balances

I understand that David and Associates will send ONE statement if I have a balance. I agree to pay my balance within 30 days from the date of the statement.

_____ **Initial**

I understand my account will accrue a \$10.00 late fee every month I fail to pay my balance. I understand that my account will be sent to a collection agency if I fail to pay my balance within 90 days of the first statement. Further, I understand that an additional 30% will be added to my balance upon submission of my account to the collection agency.

_____ **Initial**

Missed Appointments

I understand that if I do not cancel a scheduled appointment within 48 hrs of the appointment, I will be charged a "no show" fee in the amount of \$45 for cleanings and check ups and \$75 per periodontal treatment, \$50 per hour or 10% of scheduled treatment with the doctor whichever is greater.

I understand that cancellations are not accepted by leaving a voice message and I must speak to a scheduling coordinator to cancel or reschedule an appointment.

_____ **Initial**

By signing below I certify that I have read and understand the information about the Payment Policies for David and Associates Dentistry.

Signature: _____ Print Name: _____
Date: _____

David and Associates Dentistry
10991-54 San Jose Boulevard
Jacksonville, FL 32223
Phone: 904-268-0606 Fax: 904-260-7601
Contact Person: Carlos Maza C.O.O.

Authorization for Release of Identifying Health Information

Patient Name _____
Patient Address _____
Patient Phone Number _____

I authorize the professional office of my dentist named above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

You will be informed before any information is released.

- 1)Detailed description of the information to be released:
- 2)To whom the information be released (names, or classes of recipients)
- 3)The purpose for the release:
- 4)Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not you sign this authorization form. We will not refuse to treat you if you chose not to sign this form.

If you sign this form, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke authorization send us a written or electronic note telling us that your authorization is revoked. Please send this notice to the contact person listed above at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometime state or federal law changes this possibility.

I have read and understand this form. I am signing voluntarily. I authorize the disclosure of my health information as described in this form.

Dated _____ Signature _____

David and Associates Dentistry
10991-54 San Jose Boulevard
Jacksonville, FL 32223
Phone: 904-268-0606 Fax: 904-260-7601

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been given a copy of David and Associates Notice of Privacy Practices. I may also request a copy for my personal records if I wish.

Patient Name _____

Signature _____

Date: _____

We attempted to obtain written acknowledgement of receipt of privacy practices, but it could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the acknowledgement

_____ Other: (list) _____
