# Welcome

Thank you for selecting our dental healthcare team! To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help you.

**PATIENT INFORMATION** (CONFIDENTIAL) Name you would like to be called:_____

Name_____ D.O.B._____ SS: _____

Email: _____ Home PH: _____ Work No. _____ x _____

Address _____ City/State/Zip _____ Cell _____

Check Appropriate ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Age: _____ Circle: MALE FEMALE

Employer: _____ Occupation: _____

Person to Contact in Case of Emergency _____ Phone _____ Cell _____

Whom may we thank for referring you? _____ Office Last x-rays taken _____ When _____

**Responsible Party** (if different from patient)

Name_____ D.O.B._____ SS No_____

Home PH: _____ Cell PH_____ Work PH. _____ x _____ Drivers License_____

Address _____ City/State/Zip _____

Email _____ Are any other family members currently a patient in our office? _____

Methods of Payment offered: ***Cash or Personal Check, Credit Cards: Visa, MasterCard, Discover Card and American Express***

**Insurance Information** (Person who is the Subscriber (employee) on the insurance)

Insured Name_____ SS No. _____ D.O.B. _____

Employer _____ Contract/ID (from card) _____ Ins. Co. Phone _____

Insurance Company _____ Patient relationship to employee? Spouse Child Other

*THIS OFFICE SUBMITS INSURANCE AS A COURTESY TO OUR PATIENTS. THIS PRACTICE DOES NOT ACCEPT RESPONSIBILITY FOR BENEFITS PAID OR NOT PAID BY YOUR INSURANCE COMPANY. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES.*

*OUR STAFF ESTIMATES YOUR PORTION DUE AT THE TIME OF SERVICE. IF YOU WISH TO KNOW YOUR EXACT COST EACH VISIT, YOU MAY PAY IN FULL AT THE TIME OF SERVICE AND WAIT FOR YOUR INSURANCE COMPANY TO REIMBURSE YOU DIRECTLY. THIS IS THE ONLY FOOL-PROOF WAY TO ENSURE THAT YOUR ACCOUNT BALANCE REMAINS CURRENT AND ACCURATE WITH THIS OFFICE. IF INSURANCE PAYS MORE THAN EXPECTED, YOU WILL RECEIVE A REFUNDUPON REQUEST OR YOU CAN CHOOSE TO APPLY THE CREDIT TO NEXT SERVICE. IF INSURANCE PAYS LESS THAN EXPECTED, YOU WILL BE BILLED FOR THE DIFFERENCE.*

*SOME SERVICES MAY BE DOWNGRADED TO A LOWER RATED SERVICE THAN THE SERVICE WE PROVIDE FOR INSURANCE COVERAGE PURPOSES AND YOUR PLAN MAY REQUIRE YOU TO PAY THE DIFFERENCE. SOME EXAMPLES ARE POSTERIOR COMPOSITE RESTORATIONS AND CROWNS.*

**Consent:** 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. The undersigned hereby authorizes the Doctor/Staff 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 of numbness however rarely permanent. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless prior financial arrangements have been made. I understand that a finance, rebilling, collection charge or attorney fees may be added to any overdue balance of more than 60 days.

**Patient Signature (Parent of Child):** _____ _____

Name Date

***PATIENT MEDICAL HISTORY*** ***Patient Name*** _____ ***Date*** _____

Physician _____ Office PH._____ Date of Last Exam _____

1. Are you under a physicians care now? _____ Explain _____
2. Have you ever been hospitalized or had a surgical procedure? ____ In the last 5 yrs? _____ Explain _____

   _____
3. Have you ever had a serious head or neck injury? _____ Explain _____
4. Have you ever taken, Phen-Fen, Redux, Boniva, Fosamax, Actonel or any cancer medications containing bisphosphonates?
5. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?
6. Are you on a special diet? _____Explain _____
7. Do you smoke? _____use tobacco? _____How often? _____
8. Do you use controlled substances? _____Frequency? _____
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasted more than 3 wks)?_____
10. Are you allergic to any of the following: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

    Other _____, Explain _____
11. Are you taking medications (including non prescription medicines): _____ If yes, Please List: _____

    _____

Ask for a separate sheet of paper if you need it.

Women: Are you : Pregnant/Trying to get pregnant? _____ Taking Oral Contraceptives? _____ Nursing? _____

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

- ○ High Blood Pressure
- ○ Heart Attack/Failure/Disease
- ○ Rheumatic Fever
- ○ Artificial Heart Valve
- ○ Low Blood Pressure
- ○ Cortisone Medicine
- ○ Pain in Jaw Joints
- ○ Chemotherapy
- ○ Spina Bifida
- ○ Shingles
- ○ Swollen Ankles
- ○ Fainting/Dizziness
- ○ Asthma
- ○ Blood Transfusion
- ○ Recent Weight Loss
- ○ Heart Trouble
- ○ Cardiac Pacemaker
- ○ Heart Murmur
- ○ Artificial Joint
- ○ Bruise Easily
- ○ Herpes
- ○ Psychiatric Care
- ○ Renal Dialysis
- ○ Tumors or Growths
- ○ Irregular Heart Beat
- ○ Angina
- ○ Frequently Tired
- ○ Anemia
- ○ Emphysema
- ○ Cancer
- ○ Chest Pains
- ○ Easily Winded
- ○ Stroke
- ○ Blood Disease
- ○ Congenital Heart Disorder
- ○ Excessive Bleeding/Hemophilia
- ○ Radiation Therapy
- ○ Sickle Cell Disease
- ○ Yellow Jaundice
- ○ Lung Disease
- ○ Hay Fever/Allergies
- ○ Tuberculosis
- ○ Glaucoma
- ○ Leukemia
- ○ AIDS or HIV Positive/Infection
- ○ Sexually Transmitted Disease
- ○ Cold Sores/Fever Blisters
- ○ Alzheimer's Disease
- ○ Anaphylaxis
- ○ Thyroid Problem
- ○ Stomach Troubles/Ulcers
- ○ Hepatitis B or C
- ○ Hepatitis A
- ○ Kidney Diseases
- ○ Joint Replacement or Implant
- ○ Diabetes
- ○ Liver Disease
- ○ Epilepsy/Seizures/Convulsions
- ○ Arthritis
- ○ Obstructive Sleep Apnea
- ○ Use a CPAP machine

Have you had any serious illness not listed above? _____

Comments:_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

_____

Signature of patient (or parent/guardian if minor) Date

Doctors Comments: _____

_____

_____

_____ Doctor Signature _____ Date _____

# *We Care About Your Privacy*

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

The Department of Health and Human Services has established a privacy rule (HIPAA-Health Insurance Portability and Accountability Act) to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information (PHI), but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information.

If you have any objections to this form, please ask to speak with our HIPAA compliance officer. You have the right to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature_____ Date_____

Patient, Policyholder or Responsible Party

**Park Avenue Dental-Financial Policy**

As your dental provider, we are committed to providing you with the best possible dental care. In order to achieve this goal, we need your assistance and understanding of our financial policy.

**PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**-We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit.

**FINANCIAL AGREEMENT/INSURANCE COVERAGE**-***As a* courtesy, *we will bill your primary insurance on your behalf.*** You will be responsible for filing any secondary insurance coverage. We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. However, you must realize that:

- 1. Your insurance is a contract between you and the insurance company. Our office is not responsible for benefits not paid by your insurance company.
- 2. Our office ***ESTIMATES*** your portion. **This is only an estimate**. For a more exact estimate, you may request that we send in a written pre-determination *prior to the start of your treatment*. Please note that this is a lengthy process and may take 4-8 weeks before the pre-determination is processed by your insurance company.
- 3. Not all services are covered benefits under all contracts. Some insurance plans exclude coverage of certain services or **downgrade services to a less-expensive service** than the service we provide **without prior notice.**
- 4. All charges are your responsibility from the date services are rendered. You may need to contact your insurance company if there are any questions regarding the company's handling of a claim.

We must emphasize that as your dental care providers, our relationship and concern is with you and your dental health, not the insurance company.

**MISSED, CANCELLED AND RESCHEDULED APPOINTMENTS- AS A COURTESY, WE TRY TO CONTACT ALL PATIENTS TO CONFIRM THEIR APPOINTMENTS; HOWEVER, WE MAY NOT ALWAYS BE ABLE TO REACH YOU.** We ask that you give us an advanced notice of **two BUSINESS days** when cancelling or rescheduling an appointment. Of course, reasonable consideration will always be given to extenuating circumstances, such as unforeseen emergencies.

**FEES FOR MISSED/CANCELLED/RESCHEDULED APPOINTMENTS WITHOUT 2 BUSINESS DAYS NOTICE**

(In the absence of any extenuating circumstance)

| | |
|---|---|
| **DENTAL APPOINTMENTS** | **$50.00** |

***Certain longer appointments may require a larger cancellation fee and/or a deposit to schedule appointment.***

**AS YOUR APPOINTMENT TIME IS RESERVED FOR YOU WHEN YOU SCHEDULE THE APPOINTMENT, *YOU* ARE RESPONSIBLE FOR THE CHARGE REGARDLESS OF WHETHER OR NOT A COURTESY REMINDER HAS BEEN SUCCESSFUL. We NEVER schedule or pre-schedule an appointment without your consent or knowledge.**

If you have any questions about the above information or any uncertainty regarding your responsibility, please do not hesitate to ask us. We are here to help you.

**I have read and understand the Financial Policy.**

_____

**Signature**

_____ _____

**Printed Name** **Date**

Park Avenue Dental
912 NW 56 TERR Suite B
Gainesville, FL 32605

**Privacy Consent Form**

I, _____, give Park Avenue Dental my

permission to share/disclose my personal information on treatment, payment or

healthcare operations as follows:

_____Myself only

(name)_____ (relationship)_____

(name)_____ (relationship)_____

(name)_____ (relationship)_____

_____

Patient's Name (printed and signed) Date

_____

Witness (printed and signed) Date

Park Avenue Dental
912 NW 56 TERR Suite B
Gainesville, FL 32605

**PHOTOGRAPHY CONSENT FORM**

I hereby grant full permission to Park Avenue Dental to use my photograph and first and last initial to be used for educational and promotional materials as stipulated below. I understand that these photographs may also be used to lecture to other dentists, health care professionals, and/ or civic groups. This consent also serves to waive all rights of privacy or compensation which I may have in connection with the use of my photographs and/or name.

Permission to use photographs for in office education, and any publication or advertising materials ( Printed or electronic).
(initial) _____

Permission to use photographs for in office patient education and lecturing use only:
(initial) _____

_____
NAME

_____
SIGNATURE DATE