PARK Family & Cosmetic DENTISTRY
Established 2009

Patient Information

Name: _____ Preferred Name: _____

Gender: Male [ ] Female [ ] Marital Status: Married [ ] Single [ ] Child [ ] Other [ ]

Email: _____ Home #: _____ Cell #: _____

Work #: _____Birth Date: _____ Social Security #: _____

Home Address: _____

Alternate Address (Seasonal Resident): _____

Occupation: _____ Employer: _____

Emergency contact: _____ Phone #: _____ Relationship: _____

Dental History

What is your main dental concern? _____

Previous Dentist: _____ City: _____ Date of Last Visit: _____

Medical Information

Physician Name: _____ Phone #: _____ Fax #: _____

Preferred Pharmacy: _____ Phone #: _____ Location: _____

List all current medications and purpose: _____

List all medication allergies: _____

List all major illnesses: _____

List all surgeries: _____

Health History

Please circle specifics and check Yes or No to the following health history questions:

Condition	Yes	No
Heart condition, joint replacement requiring pre-medication	[ ]	[ ]
Bleeding disorder, anemia, blood transfusion	[ ]	[ ]
Heart attack, bypass surgeries, pacemaker, high blood pressure	[ ]	[ ]
Diabetes (A1C %, fasting glucose level)	[ ]	[ ]
Anxiety, depression, mental disorder	[ ]	[ ]
Asthma, COPD, tuberculosis	[ ]	[ ]
Stroke, seizures, paralysis	[ ]	[ ]
Total artificial joint replacement, arthritis	[ ]	[ ]
AIDS, lupus, seasonal allergies	[ ]	[ ]
Ulcers, acid reflux, indigestion	[ ]	[ ]
Kidney failure, dialysis, venereal disease	[ ]	[ ]
Organ transplant, pregnancy, nursing	[ ]	[ ]
Sleep apnea, TMJ pain, headaches	[ ]	[ ]
Use of tobacco, alcohol, acidic food/drink	[ ]	[ ]
Bleeding gums, cold sores, canker sores	[ ]	[ ]

Patient or Guardian Signature: _____ Date: _____ Reviewed by: _____

Referral Information

Whom may we thank for referring you to our practice?

[ ] Another Patient [ ] Billboard [ ] Email [ ] Event [ ] Healthcare Provider [ ] Internet [ ] Newsletter [ ] Other
[ ] Newspaper [ ] Postcard [ ] Radio [ ] Social Media [ ] TV [ ] Valpak [ ] Website [ ] Walk-in [ ] Team Member

Name of patient, healthcare provider, team member, or other who referred you:_____

Smile Evaluation

Do you like the appearance of your teeth and smile? Yes [ ] No [ ] Comments: _____
Are your teeth as straight as you would like them? Yes [ ] No [ ] Comments:_____
Do you have gaps you do not like? Yes [ ] No [ ] Comments:_____
Do you like the color and shape of your teeth? Yes [ ] No [ ] Comments:_____
Do you have old fillings or dental work that you do not like? Yes [ ] No [ ] Comments:_____

Patient Concerns

Rate which concern is most truthful for you (1 = Most True, 5 = Least True):

_____ Fear _____ Time _____ No Sense of Urgency _____ No Trust _____ Budget

HIPAA Privacy

By signing this Acknowledgement of Receipt of Notice of Privacy Practices, I agree that I have received a copy for review. I understand that I am giving my consent to the Practice's use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I authorize the Practice to submit my dental benefit claim to my insurance plan.

Patient or Legal Representative Signature: _____ Date: _____

Practice Policy

By signing this Practice's Policy, I agree that I have received a copy of the Policy for review. I understand that I am giving my consent to the Practice to perform procedures necessary to restore and maintain my dental health. These procedures may include but not limited to diagnostic (exam, radiographs, photos, impression…), comprehensive and preventive care treatments. I understand that withholding health and dental history information may affect the outcome of the procedures or course of treatment. The Practice can contact me to discuss matters related to this Policy. I understand that the estimated fee presented can only be valid for a period of three months from the date of the patient examination. This is due to the nature of my dental condition which can only get worse and require more extensive treatment if left untreated. I understand that the Warranty for restoration is null and void if I do not maintain the recommended interval for continuing care cleaning appointments with my hygienist, and yearly examination including dental X-rays with my dentist. This also applies when I fail to protect my oral rehabilitation restorations with a splint guard therapy device and/or fluoride trays as prescribed by treating dentists. I also respect the Practice's time and abide by the Cancelation/No Show/Last Minute Rescheduling policy. I understand that I will be charged a fee if I fail to cooperate in this sensitive issue.

Patient or patient's legal representative signature _____ Date_____

INSURANCE DISCLAIMER

Please note we do not accept nor participate in-network with any DMO/HMO/PPO insurance plans, prepay plans, Medicaid, or discount plans.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits, it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an ESTIMATE of what your insurance coverage will be, it is not a guarantee. If you need EXACT payment of benefits, then predetermination is required. If you would like this to be done, you must specify to the financial coordinator BEFORE any work is initiated. This takes 6-8 weeks.

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full on the day of treatment. If your insurance plan does not pay within 120 days of treatment, you must pay the outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check. Also, remember that dental insurance plans are not designed to cover all of your dental needs.

I have chosen to allow Park Family & Cosmetic Dentistry to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand that it is my responsibility to be aware of what type of dental plan I have. I also understand that this office cannot guarantee my insurance company will cover all services rendered and that it is only an estimate of benefits. I also understand that if my insurance company does not pay within 120 days of my date of service, then I will be responsible to pay at that time.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/USE AND DISCLOSURE FORM

We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI for treatment, payment, and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or healthcare operations.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Printed Name of Patient **Date**

_____ _____

Legal Representative **Date**

_____ _____

Printed Name of Patient **Date**

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone _____
2. Name _____ Relationship _____ Phone _____

CONSENT TO EMAIL OR TEXT FOR APPOINTMENT REMINDERS AND OTHER

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that, once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is:_____. Please initial _____

The email address that I authorize to receive email messages for appointment reminders and general health information is:_____. Please initial _____

OR

_____ **I decline** to receive communications via **text**.
_____ **I decline** to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

☐ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.

☐ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature: _____ Date requested: _____

APPOINTMENT/CANCELLATION/NO SHOW POLICY

Appointments

Prescheduled office visits are recommended, please call (239)263-1151 to reserve. The receptionist may ask about the reason for your visit. This helps us schedule the provider's time more efficiently. Please arrive 15 minutes early for your appointment. Patients who are late for any appointment may be asked to reschedule at the provider's discretion. Remember to bring all your prescriptions, over-the-counter medicines, vitamins and supplements to each visit. This will enable your provider to review the medications at each visit.

Cancellations

We would like to thank you for being a patient in our office. We value all our patients and strive to provide the best dental care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, please give us at least 2 business days' notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We know that your time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are ready for your visit. Except in the case of emergency treatment for another patient, you can expect us to be running on schedule. If you are unable to keep an appointment, we ask that you cancel at least 48 hours in advance. If this is not possible, call as soon as you can so that another patient can be given your appointment time.

Missed Appointments (Non-Cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without cancelling, someone else who could have been seen in your place is delayed unnecessarily.

We track missed (non-cancelled) appointments. A 'No Show/Late Cancellation' is defined as missing an appointment without cancelling at least 48 hours before scheduled time. There will be a charge for a missed or non-cancelled appointment. Insurance will not cover charges for no show/late cancellation fees. The $75.00 charge is an addition to any other charges you may have incurred. No refunds will be given. Repeat missed appointments may result in your provider sending a letter discharging you from the practice. We will offer 30 days of emergency care only and transfer your dental records when you find a new provider.

Payment

Payment is due in full at the time of service, no exceptions.

_____

Signature Printed Name Date