PARK Family & Cosmetic DENTISTRY

Name: _____ Preferred name: _____ male__ female__ married__ single__ child__ other__

Email:_____ home#_____ cell#_____ work#_____

Birth Date: _____ social security #:_____

Home Address: _____

Alternate address for seasonal resident: _____

Occupation: _____ Employer: _____

Emergency Contact name: _____ phone #:_____ relationship: _____

What is your main dental concern: _____

Previous dentist name: _____ city: _____ date of last dental visit:_____

Physician Name: _____ phone #:_____ fax #_____

Please list all current medications and purpose: _____

_____

List all medication allergies:_____

List all major illness: _____

List all surgeries: _____

Please check Yes or No to the following health history questions. Circle specific and provide additional info at the end.

**Yes No**

__ __ heart condition, &/or total joint replacement which requires Antibiotic Pre-Med 1 hour before dental appointment
name of antibiotic, if yes _____

__ __ bleeding disorder, excessive bleeding, anemia, blood transfusion

__ __ heart attack, heart failure, bypass surgeries, pacemaker, chest pain, heart murmur, MI, high blood pressure_____

__ __ diabetes (A1C % _____; fasting glucose level _____), hyperthyroid, hypothyroid, high cholesterol

__ __ anxiety, depression, insomnia, mental disorder, nervousness, fainting, dizziness

__ __ asthma, COPD, shortness of breath, wheezing, congestion, tuberculosis

__ __ stroke, seizures, paralysis, headache, numbness

__ __ cancer, tumor, chemotherapy, radiation treatment,

__ __ total artificial joint replacement type _____date _____, rheumatism, arthritis, swollen joints

__ __ AIDS, lupus, seasonal allergies

__ __ ulcers, acid reflux, indigestion, stomach problem

__ __ kidney failure, dialysis, frequent urination, venereal disease

__ __ hepatitis type _____ jaundice, liver disease, chronic alcohol abuse

__ __ organ transplant type _____ date _____

__ __ pregnancy – due date_____ nursing

__ __ earache, hard of hearing, sinus issue, mouth breathing, dry mouth

__ __ sleep apnea, head injury, TMJ pain, TMJ noise, frequent headaches

__ __ take medication for blood thinner, stronger bone, long term corticosteroid use_____

__ __ smoke, smokeless tobacco, drink alcohol, drink sodas or sweet drinks, consume acidic food/drink

__ __ bleeding gums, bad taste in mouth, herpes-cold sore, canker sore

Patient or guardian signature: _____date: _____ reviewed by: _____

Whom may we thank for referring you to our practice?

Another patient _____ Other healthcare Prov _____Valpack _____

__Living Local__BNI __Chris Ad Flyer __ Triadex Laminated Card __Event __ Insurance __Internet/website

__YellowPgs __Previous patient __ Signage/Walk-in ___NaplesDailyNews ___StaffMember_____

Please answer Yes or No to your smile evaluation questions and explain as needed:

**Yes No**

__ __ Do you like the appearance of your teeth, your smile? _____

__ __ Are your teeth as straight as you would like them? _____

__ __ Do you have gaps that you do not like? _____

__ __ Do you like the color of your teeth? _____

__ __ Do you like the shape of your teeth? _____

__ __ Do you have old fillings or dental work that you do not like? _____

We'd like to get to know our patients as best as we can. These are 5 reasons people often hesitate, or put off, seeking dental treatment. If you could please rate which is true for you; 1 being the most true, and 5 being the least true, it will help us better understand your needs.

____ Fear ____ Time ____ No sense of urgency ____ No trust ____ Budget

**HIPPA PRIVACY**

By signing this Acknowledgement of Receipt of Notice of Privacy Practices Notice, I agree that I have received a copy of the Notice 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 patient's legal representative signature _____ Date _____

**PRACTICE'S 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.

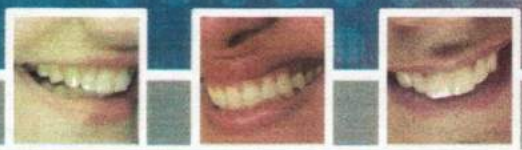
I also respect the Practice's time and abide by the Cancelation/No Show/Last Minute Rescheduling policy. I understand that I will be charged a fee if I fail to cooperate in this sensitive issue.

Patient or patient's legal representative signature _____ Date _____

Park Family & Cosmetic Dentistry
690 Goodlette Rd North
Naples, FL 34102-5613

(239)263-1151

www.myparkdental.com
info@myparkdental.com



# 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 a predetermination is required. If you would like this 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 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 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 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 become responsible to pay at that time.

Signature: _____ Date: _____

Response Date: 10/12/2017

PARK
Family & Cosmetic
DENTISTRY
Established 2009

239-263-1151
690 Goodlette Frank Rd. N., Naples, FL 34102
www.MyParkDental.com

*Change your smile, change your life!*

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

**Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). 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 about you 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 — Legal Relationship to the Patient (*If required)*

_____ _____

Signature of Patient or Legal Representative — Date

_____ _____

Printed Name of Patient — Legal Relationship to the Patient (*If required)*

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 healthcare communication.**

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: _____