PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name ______________________ Preferred name ____________ Birth date __________
If minor, parents name ______________________ Best contact phone number (_______) ______________
Mailing address ______________________ City ____________ State ________ Zip __________
Employer ______________________ Occupation ______________________
Spouse's name ______________________ Spouse's employer ______________________ ❑ Unmarried
How did you learn about our office? ______________________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance
Your Social Security number: ______________ Dental Insurance Co. ______________ Group number __________
Covered by spouse's insurance? ❑ yes ❑ no Insurance Co. Phone ______________________
Spouse's dental insurance company ______________ Group number ______________
Spouse's birthday ______________ Social Security number ______________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(PLEASE Circle YES or NO)

Y N Cancer or tumor
Y N Heart ailment or chest pains
Y N Heart murmur, mitral valve prolapse, heart defect
Y N Osteoporosis
Y N Artificial joint or valve
Y N HIGH or LOW blood pressure (circle one)
Y N Pacemaker
Y N Tuberculosis or other lung problems
Y N Kidney disease
Y N Hepatitis or other liver disease
Y N Alcoholism
Y N Blood transfusion
Y N Diabetes
Y N Neurologic condition
Y N Epilepsy, seizures, or fainting spells
Y N Emotional condition
Y N Arthritis
Y N Herpes or cold sores
Y N AIDS or HIV positive
Y N Migraine headaches or frequent headaches
Y N Anemia or blood disorders
Y N Abnormal bleeding after extractions, surgery, or trauma
Y N Hay Fever or sinus trouble
Y N Allergies or hives
Y N Asthma
Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other: ______________________

Please list medications or supplements you take:

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- ❑ May be pregnant
  Expected delivery date: __________
- ❑ Taking hormones or contraceptives

Name of your physician: ______________ **Emergency Contact AND Phone Number** ______________________

List any family member with whom you give us permission to discuss treatment: ______________________

Do you have any disease, condition, or problem not listed above? ______________________

Please add anything else you would like us to know about: ______________________

Reason for today's visit: ______________________

Signature of patient (or parent) ______________________ Date ______________

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Patient Financial Agreement

Friendly Dental requires all patients to make financial arrangements with us before we provide treatment.

1. I understand that full payment is due at the time of service for myself and any party for whom I am financially responsible.

2. I understand that it is solely my responsibility to confirm which treatments or procedures are covered and/or paid by my insurance (including, but not limited to, any applicable exclusions, deductibles, annual or lifetime maximums).

3. I understand that although I pay my estimated patient balance on the date of service, the insurance estimate may differ from what my insurance carrier ultimately pays. I will be responsible for any amounts not paid by my insurance for any reason, and I may receive a bill/statement for a balance due which will be immediately payable upon receipt. Credit balances will remain on my account unless I request a refund.

4. I understand that as a courtesy, Friendly Dental will attempt to verify my insurance coverage from information that I provide and will file two claims per appointment, in accordance with all contracted agreements with the insurance payor(s). Your personal health information (PHI) may be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits. I am required to pay in full, before treatment is performed, the estimated portion of any procedures or treatment that will not be covered by my insurance.

5. I understand that insurance claims will only be filed if I provide Friendly Dental with my social security and insurance identification numbers (if applicable). If I choose not to provide Friendly Dental with my social security number, I understand that I must pay in full for all services rendered. It is Friendly Dental's policy to require social security numbers and a copy of a government-issued picture identification (driver's license) for recordkeeping purposes even though that may not be the policy of my insurance carrier.

6. I understand that Friendly Dental currently charges $40.00 for a broken or cancelled appointment unless 24 hours advance notice is given. This fee is subject to change without notice.

7. I understand that unless patient records are sent directly to another provider, the charge for copies of x-rays is $18.00 and treatment information is $5.00 or the maximum amount allowed by law or my insurance carrier. These fees are subject to change without notice.

8. I understand that I must inform Friendly Dental, in writing, of any concerns, questions or disputes I may have concerning my treatment or charges in a timely manner, but not more than 30 days from either the completion of the procedure or awareness of dispute.

9. I understand that all account balances over 30 days will incur an interest charge at the maximum legal rate allowed.

10. I understand that I will be charged the maximum service charge allowed by law for any returned check, electronic authorization or any debit sent or provided to Friendly Dental for payment.

11. I understand that if I fail to pay my account upon it becoming due, Friendly Dental may report my account to credit rating bureaus or to a collection agency and/or take legal action against me for full payment, including but not limited to all related reasonable attorney's fees, collection and/or court costs.

12. I understand it is my responsibility to notify Friendly Dental of any changes to my address, phone number, insurance changes, etc.

13. I authorize payment of the dental benefits, otherwise payable to me, be made directly to Friendly Dental.

14. I understand that if I discontinue treatment for a requested procedure, including but not limited to, partials, dentures, crowns, bridgework and surgical preparatory work, I remain responsible for paying all lab related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled for discontinued treatment and I may receive a bill / statement for a balance due.

15. REFUND OF PRODUCTS: I understand that Friendly Dental's return policy for unopened or unused non-prescription products is thirty(30) days from the date of purchase. Non-prescription products include, but are not limited to, toothbrushes, or other non-prescription merchandise. By law, prescription products cannot be returned which include but are not limited to, whitening products or toothpastes.

I have thoroughly read, understand and agree to the above terms and conditions.

Printed Name

Date

Signature of Patient (or authorized guardian)

If authorized guardian, relationship to patient

16520 S. Tamiami Trl, Ste 106
Fort Myers, FL 33908

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________ have received a copy of this office's Notice of Privacy Practices.
(PLEASE PRINT NAME)

____
Signature

____
Date

*You May Refuse To Sign This Acknowledgement

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

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PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the results of tests, treatment plans, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Friendly Dental, PA to release my records and any Information requested to the following individuals.

1. ________________________________ **Relation to Patient:**__________________
2. ________________________________ **Relation to Patient:**__________________
3. ________________________________ **Relation to Patient:**__________________
4. ________________________________ **Relation to Patient:**__________________

Authorization Regarding Messages

(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with ____

____ ______________

Patient Name (PLEASE PRINT) **Date**

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Patient Signature