

## PATIENT LAST NAME:

	FIN31:	INTERAL:		
How do you wish to be addressed?		Date of Birth		
Address	City	State	Zip	
Telephone (Mobile)		(Home)		
Email				
How did you hear about our practice?				

TIDOT

#### **INSURANCE INFORMATION**

Primary Insurance	Secondary Insurance
Subscriber Name	Subscriber Name
Subscriber ID	Subscriber ID
Date of Birth	Date of Birth
Relationship to Subscriber	Relationship to Subscriber □Self □Spouse □Child □Other
Employer Name	Employer Name
Employer Phone	Employer Phone
Insurance Company	Insurance Company
Insurance Group	Insurance Group
Insurance Phone	Insurance Phone

Please present your insurance card to be photocopied for our records.

#### **RESPONSIBLE PARTY** (If minor)

Last Name:	First:	Initial:
Address (If different)		Date of Birth
City	State	Zip
Telephone (Home)	(Work)	(Mobile)
Email		

#### **EMERGENCY CONTACT**

Last Name:	First:	Initial:
Telephone (		

#### AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

**ELECTRONIC COMMUNICATIONS.** I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by informing the office @ 941-795-8100.

I attest to the accuracy of the information on this page.

Signature			
(Responsible	Party,	if under	18)

\_ Date \_\_\_

# PATIENT REGISTRATION

TRIT'T'T A T



### PLEASE COMPLETE ALL INFORMATION – THANK YOU

### PATIENT LAST NAME: \_

# \_ PATIENT FIRST NAME: \_\_

Reason for today's Visit	DENTAL HISTORY										
Enumer         Date of last denial x-rays           Please check if you have/hat:         Yes No         Yes No         Yes No         Yes No           Quested in the only is or muth         Due of heat denial x-rays         Hore you ore had halfegic reaction to Neucosine, local, or general members/27 Urse Who         Hore you ore had halfegic reaction to Neucosine, local, or general members/27 Urse Who           Date of last denial x-rays         Hore you ore had halfegic reaction to Neucosine, local, or general members/27 Urse Who         Hore you ore had halfegic reaction to Neucosine, local, or general members/27 Urse Who           Chew on one adde drimuth         Mouth breathing         Hore you ore had halfegic reaction to Neucosine, local, or general members/27 Urse Who           Own or general members/         Mouth breathing         Hore you ore had halfegic reaction to Neucosine, local, or general members/27 Urse Who           Provide of the origen moding         Mouth breathing         Hore you ore had halfegic reaction to Neucosine, local, or general members/27 Urse Who           Provide of the origen moding         Mouth breathing         Date of last visit           Provide of the origen moding         Hore you ore had half half who you or any origen moding           Grown on one date at half or transfusion         Yes No         Yes No           Provide on the origen half half who you or any origen half who you any serious lines or any origen half half who you any serious half halfore provide half half whore provide half half whore p	Reason for today's visit							_ Date	e of last dental visit		
Please check if you have/had:         Yes         No         Here you ever had an allergic reaction to Noocaine, local, or general areas/helics?         Use of check Huling         Image sensition to reaction to Noocaine, local, or general areas/helics?         Type sensition to non-presented in the sensition to Noocaine, local, or general areas/helics?         Type sensition to non-presented in the sensition to Noocaine, local, or general areas/helics?         Type sensition to non-presented in the sensition to Noocaine, local, or general areas/helics?         Type sensition to non-presented in the sensition to Noocaine, local, or general areas/helics?         Type sensition to Noocaine, local, helics areas/helics?         Type sensition to Noocaine, local, or general areas/helics?         Type sensition the sensition to Noocaine, local, helics areas/helics?         Type sensition to Noocaine, local, helics areas/helics?         Type sensition to Noocaine, local, helics areas/helics areas/helics?         Type sensites areas/	Former dentist										
and breach an alterior reaction to Novocaine, local, program an advecting of an alterior reaction to Novocaine, local, program and strainers in the Novocaine in Control Cambrid Cambri											
Bisters on tips or mouth bring encloses beth or broken filings or general analythetes? "Yes No Hinds encloses beth or broken filings or general analythetes? "Yes No Hinds encloses beth or broken filings or general analythetes? "Yes No Hinds encloses beth or broken filings or general analythetes? "Yes No Hinds encloses beth or broken filings or general analythetes? "Yes No Hinds encloses beth or broken filings or general analythetes? "Yes No Hinds encloses beth or broken filings or general analythetes? "Yes No Hinds encloses beth or broken detains and the encloses beth or broken do you broken do you broken? Clean degine beth general filings of the encloses explain do you broken? They were had trouble from previous dental care? They filing beth or often do you floss? General disease explain do you broken do you broken? They were had trouble from previous dental care? They filing and they dete do you broken? They were had analytic to pressure or initiants or they do you for the do you broken? They were had analytic to pressure or initiants or they do you be and they do you be and you broken? They were had analytic to analytic to pressure or initiants or they do you be analytic to pressure or pressure o	,			Head.	neck, jaw pain, or aches				Have you ever had an allergic reaction to Novocair	ne, loo	cal,
Chevion one safe of mouth Chevion one safe of mouth Chevion or light structure Chevion or light structure Structure Structure Structure Structure Structure Chevion or give factor Structure Chevion or give factor Chevion of the Structure Ch					• •				or general anesthetics?  Yes  No		
Cigarette, pipe, or cigar smoking       Orthodonit treatment         Smokeless totacco       Nitrous Oxide         Dy mouth       Periodontal testament         Food collection between teeth       Sensitivity to pressure or intratus         Cench or grind teeth       Ciol(), test, sweets)         Growths or sore spotis in your mouth       How often do you floss?         MetDicAL HISTORY       Date of last visit         Physician's address       Blood Pressure         Have you ever had a biodor transfusion       Yes         No Lif yes, joile as educations       Yes         Wormen Ar evo pregnant?       Yes         No Lif yes, joile as educations       Yes         No Lif yes, joile as educations       Yes         No Lif yes, joile as educations       Yes         Mareina       Head throw flem do you brosh?         Please check if you have/had:       Yes         Yes       No       Yes         Anthridia, hay fever, sinustis       Head throw there so in the so in t	Burning sensation on tongue			Loose	teeth or broken fillings		_		If Yes, please explain		
Simulations       Nitrous Oxide	Chew on one side of mouth	_		Mouth	breathing		_				
Pay modified       Periodonial restment       Image: source or initiatis         Food collection between teeth       Sensitivity to pressure or initiatis       Image: source or initiatis         Growths or sace spots in your mouth       How oten do you thos?       Image: source or initiatis         Growths or sace spots in your mouth       How oten do you thos?       Image: source or initiatis         MEDICAL HISTORY       Image: source or initiatis       Image: source or initiatis         Medical source       Date of last visit       Image: source or initiatis         Have you ever had a blood transfusion Yes       No       If yes, please describe         Have you ever had a blood transfusion Yes       No       If yes, give approximate dates         (Women) Are you pregnant?       Yes       No       Taking birth control pilis?       Yes       No         Atergies, hay fever, sinustis       Headaches       Stoke       Image: source or initiatis       Image: source or initisource or initiatis       Image: source or initiatis							_				
Food collection between teach Sensitivity to pressure or initiants Here you were had trouble from previous dental care?   Clench or gind teach (cold, head, sweets)   Growths or so e pots in your mouth How often do you forss?   Gumes worken, tender or bleeding How often do you forss?   MEDICAL HISTORY   Physician's address   Blood Pressure   Have you had any serious illnesses or operations   Yes   No   If yes, please describe   Ware you had any serious illnesses or operations   Yes   No   If yes, give approximate dates   (Women) Are you pregnant?   Yes   No   If yes, give approximate dates   (Worker, sinustis)   Heat query end wer, sinustis   Heat problems   Antricial heart valves   Heat problems   Stoke fee or ankles   Arthicial heart valves   Heat problems   Arthicial heart valves   Heat problems   Arthicial heart valves   Heat problems   Arthicial ginths   Arthicial ginths   Arthicial heart valves   Heat problems   Arthicial heart valves   Heat problems   Arthicial heart valves   Heat problems   Arthicial ginth   Arthicial ginth   Arthicial heart valves   Heat problems   Arthicial heart valves   Heat problems   Arthicial heat valves   Bleeding							_				
Clench or grind tech <ul> <li>(cold, heat, sweets)</li> <li>How often do you floss?</li> <li>Growths or sore spots in your mouth</li> <li>How often do you floss?</li> <li>MEDICAL HISTORY</li> </ul> MEDICAL HISTORY   Physician's address Blood Pressure No If yes, give approximate dates Verse No If yes, give approximate dates Storke Please check if you have/had: Yes No If yes, give approximate dates Storke Storke Storke Storke Please check if you have/had: Yes No If yes, give approximate dates Storke Storke Storke Storke Please check if you have/had: Yes No Headaches Storke Storke Storke Cancer Of last visits Headaches Storke Storke Cancer Oster of last visits Headaches Storke Cancer Oster of last visits Headaches Storke Storke Cancer Oster of last visits Headaches Storke Cancer Oster of last visits Please check if you have/had: Yes No Ves Ves No Taking birth control pills? Yes No Taking birth control pills? Ves No Taking birth control pills? V		_				_	_		Have you over had trouble from provious deptal or	aro?	
crowth or sore spots in your mouth					• •						
Curns swollen, tender or bleeding       How often do you brush?         MEDICAL HISTORY         Physician's darderss       Date of last visit         Physician's darderss       Blood Pressure         Have you had any serious illnesses or operations       Yes       No       If yes, give approximate dates         (Wornen) Are you pregnant?       Yes       No       If yes, give approximate dates       If wes, give approximate dates         Please check if you have/had:       Yes       No       Yes       No       Taking birth control pills? Yes       No         Please check if you have/had:       Yes       No       Headaches       Slow haaling wounds       Improved pregnant?         Antentia       Improved pregnant?       Head problems       Slow haaling wounds       Improved pregnant?         Arthcia joints       Improved pregnant?       Head problems       Slow haaling wounds       Improved pregnant?         Arthcia joints       Improved pregnant?       Head problems       Slow haaling wounds       Improved pregnant?         Arthcia joints       Improved pregnant?       Head problems       Slow haaling wounds       Improved pregnant?         Arthcia joints       Improved pregnant?       Head problems       Slow heading wounds       Improved pregnant?         Arthcia joints       I	-				-						
Physician's address											
Physician's address       Blood Pressure         Have you had any serious illnesses or operations Yes   No   If yes, give approximate dates       Image: Control of Con	MEDICAL HISTORY										
Have you had any serious illnesses or operations Yes No If yes, please describe   Have you ever had a blood transfusion Yes No If yes, give approximate dates   (Women) Are you pregnant? Yes No Taking birth control pills? Yes No   Please check if you have/name Image: spinor s	Physician's name							_ D	Pate of last visit		
Have you ever had a blood transfusion Yes       No       If yes, give approximate dates         (Women) Are you pregnant? Yes       No       Due date       Nursing? Yes       No       Taking birth control pills? Yes       No         Please check if you have/had:       Yes       No       Yes       No       Taking birth control pills? Yes       No         Allergies, hay fever, sinusitis       Image: head aches       Stow healing wounds       Image: head aches       Image: head aches <td>Physician's address</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Blood Pressure</td> <td></td> <td></td>	Physician's address								Blood Pressure		
(Women) Are you pregnant? Yes       No       Due date       Nursing? Yes       No       Taking birth control pills? Yes       No         Please check if you have/had:       Yes       No       Yes       No       Yes       No         Allergies, hay fever, sinusitis       Image: Heart numurur       Stroke       Image: Str	Have you had any serious illnesses of	or op	erations	s Yes (	🗋 No 🖵 If yes, pleas	e describ	e				
Please check if you have/had:       Yes       No       Yes       No       Yes       No         Allergies, hay fever, sinusitis         Headtaches       Stowhealing wounds           Anemia        Heart murmur       Stroke            Arthritis, Rheumatism        Heart problems       Swelling of feet or ankles           Arthritis, Rheumatism        Heapt problems       Thyroid problems           Artificial joints        Heapters       Tonsilits           Astima        Heipes       Tonsilits            Astima        High blood pressure        Tuberculosis           Bate of last episode        Kidney disease        Ulcer           Date of last episode gia abnormally with operations or surgery        Low blood pressure        Do you wear contact lenses?           Bleeding abnormally with operations or surgery        Low blood pressure       Do you consume alcoholic beverages?           Cancer        Osteoporosis </td <td>Have you ever had a blood transfusion</td> <td>on `</td> <td>Yes 🗖</td> <td>No 🗖</td> <td>If yes, give approximat</td> <td>te dates _</td> <td></td> <td></td> <td></td> <td></td> <td></td>	Have you ever had a blood transfusion	on `	Yes 🗖	No 🗖	If yes, give approximat	te dates _					
Allergies, hay fever, sinusitis <ul> <li>Head aches</li> <li>Slow healing wounds</li> <li>Anemia</li> <li>Heart murmur</li> <li>Stroke</li> <li>Arthritis, Rheumatism</li> <li>Heart problems</li> <li>Stroke</li> <li>Thyroid problems</li> <li>Arthritis, Rheumatism</li> <li>Heart problems</li> <li>Thyroid problems</li> <li>Thyroid problems</li> <li>Arthritis and tailes</li> <li>Heapetilis type</li> <li>Thyroid problems</li> <li>Tuberculosis</li> <li>Tuberculosis</li> <li>Anstima</li> <li>High blood pressure</li> <li>Tuberculosis</li> <li>Tumor or growth on head/neck</li> <li>Jaundice</li> <li>Ulcer</li> <li>Jaundice</li> <li>Ulcer</li> <li>Jaundice</li> <li>Ulcer</li> <li>Venereal disease</li> <li>Ulcer</li> <li>Blood disease, clotting disorders</li> <li>Kidney disease</li> <li>O steoporosis</li> <li>Do you wear contact lenses?</li> <li>Chemical dependency</li> <li>Osteoporosis</li> <li>Do you consume alcoholic beverages?</li> <li>Chemical dependency</li> <li>Radiation treatments</li> <li>Respiratory disease</li> <li>Weight loses specify</li> </ul> <li>Consume alcoholic beverages?</li> <li>Consume alcoholic beverages?</li> <li>Respiratory disease</li> <li>Weight loses specify</li> <ul> <li>Consume alcoholic beverages?</li> <li>Respiratory disease</li> <li>Weight lose specify</li> <li>Consume alcoholic beverages?</li> <li>Respiratory disease<td>(Women) Are you pregnant? Yes</td><td>N</td><td>DI 🗖 Di</td><td>ie date</td><td></td><td>Nursing</td><td>? Ye</td><td>es 🗖</td><td>No <math>\Box</math> Taking birth control pills? Yes <math>\Box</math></td><td>No</td><td>o 🗖</td></li></ul>	(Women) Are you pregnant? Yes	N	DI 🗖 Di	ie date		Nursing	? Ye	es 🗖	No $\Box$ Taking birth control pills? Yes $\Box$	No	o 🗖
Allergies, hay fever, sinusitis <ul> <li>Head aches</li> <li>Slow healing wounds</li> <li>Anemia</li> <li>Heart murmur</li> <li>Stroke</li> <li>Arthritis, Rheumatism</li> <li>Heart problems</li> <li>Stroke</li> <li>Thyroid problems</li> <li>Arthritis, Rheumatism</li> <li>Heart problems</li> <li>Thyroid problems</li> <li>Thyroid problems</li> <li>Arthritis and tailes</li> <li>Heapetilis type</li> <li>Thyroid problems</li> <li>Tuberculosis</li> <li>Tuberculosis</li> <li>Anstima</li> <li>High blood pressure</li> <li>Tuberculosis</li> <li>Tumor or growth on head/neck</li> <li>Jaundice</li> <li>Ulcer</li> <li>Jaundice</li> <li>Ulcer</li> <li>Jaundice</li> <li>Ulcer</li> <li>Venereal disease</li> <li>Ulcer</li> <li>Blood disease, clotting disorders</li> <li>Kidney disease</li> <li>O steoporosis</li> <li>Do you wear contact lenses?</li> <li>Chemical dependency</li> <li>Osteoporosis</li> <li>Do you consume alcoholic beverages?</li> <li>Chemical dependency</li> <li>Radiation treatments</li> <li>Respiratory disease</li> <li>Weight loses specify</li> </ul> <li>Consume alcoholic beverages?</li> <li>Consume alcoholic beverages?</li> <li>Respiratory disease</li> <li>Weight loses specify</li> <ul> <li>Consume alcoholic beverages?</li> <li>Respiratory disease</li> <li>Weight lose specify</li> <li>Consume alcoholic beverages?</li> <li>Respiratory disease<td>Please check if you have/had:</td><td></td><td>Yes</td><td>s No</td><td></td><td>Yes</td><td>No</td><td></td><td></td><td>Yes</td><td>No</td></li></ul>	Please check if you have/had:		Yes	s No		Yes	No			Yes	No
Arthritis, Rheumatism Are you currently under the care of a Physician? Are you altergic/sensitive to Latex? Are you altergic/sensitive to Latex? Are you altergic/sensitive to Are you are taking: Criculatory problems Are you are taking: Fainting Glaucoma Are you are taking: Fainting Are you are taking: Faintisg Are you are taking: Fainting Are you are taking: Fainti	-				Headaches			S	Slow healing wounds		
Artificial heart valves <ul> <li>Hepatitis type</li></ul>	Anemia				Heart murmur			S	Stroke		
Artificial joints       Impress in the pression in the	Arthritis, Rheumatism				Heart problems			S	Swelling of feet or ankles		
Asthma       Image: High blood pressure       Image: Tuberculosis       Image: Tuberculosis         Required Hospitalization       Any immune deficiency       Image: Tumor or growth on head/neck	Artificial heart valves				Hepatitis type			Т	hyroid problems		
Required Hospitalization       Any immune deficiency       Tumor or growth on head/neck       Image: Constraint of the state of t	Artificial joints				Herpes			Т	onsilitis		
Have you used steroids	Asthma				High blood pressure			Т	uberculosis		
Date of last episode <ul> <li>Kidney disease</li> <li>Venereal disease</li> <li>Venereal disease</li> <li>Weight loss, unexplained</li> <li>Blood disease, clotting disorders</li> <li>Mitral valve prolapse</li> <li>Do you wear contact lenses?</li> <li>Cancer</li> <li>Osteoporosis</li> <li>Do you consume alcoholic beverages?</li> <li>Chemical dependency</li> <li>Osteoporosis</li> <li>Do you consume alcoholic beverages?</li> <li>Chemotherapy</li> <li>Pacemaker</li> <li>Are you currently under the care of a Physician?</li> <li>Corticulatory problems</li> <li>Radiation treatments</li> <li>Respiratory disease</li> <li>If Yes, please specify</li> <li>Scarlet fever</li> <li>Scarlet fever</li> <li>Sinus trouble</li> <li>Sinus trouble</li> <li>Sinus trouble</li> <li>Skin rash</li> <li>Skin rash</li> <li>Date</li></ul>	Required Hospitalization				Any immune deficiency			Т	umor or growth on head/neck		
Bleeding abnormally with operations or surgery  Low blood pressure  Weight loss, unexplained  Blood disease, clotting disorders  Mitral valve prolapse  Do you wear contact lenses?  Cancer  Osteoporosis  Do you consume alcoholic beverages?  Chemical dependency  Pacemaker  Patient/Guardian Signature Date	Have you used steroids				Jaundice			U	Jlcer		
Blood disease, clotting disorders       Imitral valve prolapse       Do you wear contact lenses?       Imitral valve prolapse         Cancer       Imitral valve prolapse       Do you wear contact lenses?       Imitral valve prolapse       Imitral valve p	Date of last episode				Kidney disease			V	/enereal disease		
Cancer       Osteoporosis       Do you consume alcoholic beverages?       Image: Consume alcoholic beverages?         Chemical dependency       Osteopenia       Are you currently under the care of a Physician?       Image: Consume alcoholic beverages?         Chemotherapy       Pacemaker       Are you currently under the care of a Physician?       Image: Consume alcoholic beverages?         Circulatory problems       Radiation treatments       Are you allergic/sensitive to Latex?       Image: Consume alcoholic beverages?         Cortisone treatments       Radiation treatments       Allergic to Penicillin, Aspirin, or other drugs?       Image: Consume alcoholic beverages?         Cough, persistent or bloody       Respiratory disease       If Yes, please specify         Diabetes       Scarlet fever       Image: Consume alcoholic beverages?         Emphysema       Shortness of breath       List any medications that you are taking:         Epilepsy       Sinus trouble       Image: Consume alcoholic beverages?         Fainting       Skin rash       Image: Consume alcoholic beverages?         I have read and answered the above questions to the best of my knowledge.       Date	Bleeding abnormally with operations or su	urgery			Low blood pressure			V	Veight loss, unexplained		
Chemical dependency       Image: Chemotherapy       Image: Chemotherapy<	Blood disease, clotting disorders				Mitral valve prolapse			D	Do you wear contact lenses?		
Chemotherapy       Pacemaker       Are you allergic/sensitive to Latex?       Image: Control of the problem of th	Cancer				Osteoporosis			D	Do you consume alcoholic beverages?		
Circulatory problems   Circulatory problems Radiation treatments   Cortisone treatments Respiratory disease   Cough, persistent or bloody Rheumatic fever   Diabetes Scarlet fever   Emphysema Shortness of breath   Eilepsy Sinus trouble   Fainting Sickle cell anemia   Glaucoma Skin rash   I have read and answered the above questions to the best of my knowledge. Patient/Guardian Signature Date	Chemical dependency				Osteopenia			A	Are you currently under the care of a Physician?		
Cortisone treatments       Image: Construction of the second	Chemotherapy				Pacemaker			A	Are you allergic/sensitive to Latex?		
Cough, persistent or bloody <ul> <li>Rheumatic fever</li> <li>Scarlet fever</li> <li>Scarlet fever</li> <li>Scarlet fever</li> <li>List any medications that you are taking:</li> <li>Sinus trouble</li> <li>Sinus trouble</li> <li>Sickle cell anemia</li> <li>Skin rash</li> </ul> <li>AUTHORIZATION AND RELEASE         <ul> <li>Skin rash</li> <li>Date</li> <li>Date</li> </ul> </li>	Circulatory problems				Radiation treatments			A	Allergic to Penicillin, Aspirin, or other drugs?		
Diabetes       Image: Scarlet fever       Image: Im	Cortisone treatments				Respiratory disease			lf	f Yes, please specify		
Emphysema       Image: Shortness of breath       Image: List any medications that you are taking:         Epilepsy       Image: Sinus trouble       Image: List any medications that you are taking:         Fainting       Image: Sickle cell anemia       Image: List any medications that you are taking:         Glaucoma       Image: Skin rash       Image: List any medications that you are taking:         AUTHORIZATION AND RELEASE       Image: List any medications that you are taking:         I have read and answered the above questions to the best of my knowledge.       Date         Patient/Guardian Signature       Image: Date	Cough, persistent or bloody				Rheumatic fever			_			
Epilepsy       Image: Sinus trouble       Image: Sinus trouble         Fainting       Image: Sickle cell anemia       Image: Sickle cell anemia         Glaucoma       Image: Skin rash       Image: Skin rash         AUTHORIZATION AND RELEASE       Image: Skin rash       Image: Skin rash         I have read and answered the above questions to the best of my knowledge.       Image: Skin rash       Image: Skin rash         Patient/Guardian Signature       Image: Skin rash       Image: Skin rash       Image: Skin rash	Diabetes				Scarlet fever			_			
Fainting       Image: Sickle cell anemia       Image: Sickle cell anemia         Glaucoma       Image: Skin rash       Image: Skin rash         AUTHORIZATION AND RELEASE       Image: Skin rash       Image: Skin rash         I have read and answered the above questions to the best of my knowledge.       Image: Skin rash       Image: Skin rash         Patient/Guardian Signature       Image: Skin rash       Image: Skin rash       Image: Skin rash	Emphysema				Shortness of breath			L	ist any medications that you are taking:		
Glaucoma Glaucoma     AUTHORIZATION AND RELEASE     I have read and answered the above questions to the best of my knowledge.   Patient/Guardian Signature Date	Epilepsy				Sinus trouble			_			
AUTHORIZATION AND RELEASE  I have read and answered the above questions to the best of my knowledge.  Patient/Guardian Signature Date	Fainting				Sickle cell anemia			_			
I have read and answered the above questions to the best of my knowledge. Patient/Guardian Signature Date	Glaucoma				Skin rash			_			
I have read and answered the above questions to the best of my knowledge. Patient/Guardian Signature Date	AUTHORIZATION AND RELEASE										
	I have read and answered the above questions to the best of my knowledge.										
Reviewed by: Date	Patient/Guardian Signature								Date		
	Reviewed by:								Date		

# DENTAL & MEDICAL HEALTH HISTORY

# **MEDICAL HEALTH HISTORY – UPDATE AND EXCEPTIONS**

I have read my medical history and confirm that it adequately states past and present conditions

DATE	EXCEPTIONS	NONE	PATIENT INITIALS	REVIEWED BY



#### SECTION A: PATIENT GIVING CONSENT

Patient Name:

Address:

Telephone:

E-mail:

Social Security Number: \_\_\_\_\_

Patient Number:

## SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer:	Dr. Katie Tulipano
Telephone:	Phone: 941-795-8100
Address:	6060 43rd Avenue West Brandenton FL 34209

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

# **SECTION C: SIGNATURE**

\_\_\_\_ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature:

Date:

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

#### SECTION D: 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)

Signature:

Date:

You are entitled to a copy of this consent after you sign it.

# **PRIVACY PRACTICES RECEIPT / CONSENT FORM**

#### CORTEZ GARDENS

## SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:

Date:

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

## SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I, \_\_\_\_\_\_, understand that by signing this Consent form, I am giving my consent to Dr. Katie Tulipano D.M.D. to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: \_\_\_

Relationship: \_\_\_\_

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

Patient's Signature (Legal Guardian, if Patient is a minor)

## SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request restrict the disclosure of my PHI to those specified below:

	Name:		
	Name:		
Signature:		Date:	
If this Restrict	tion of PHI is s	signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:	
Personal Rep	resentative's N	Name:	
Relationship to	o Patient:		

Date:



#### PATIENT NAME:

DATE:

- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.
- WE PROVIDE INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.

#### ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

#### MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

#### **UNACCOMPANIED MINORS**

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover.

#### **INSURANCE**

We provide insurance company billing as a <u>courtesy</u> to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by our team regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to Dr. Katie Tulipano. However, if you are paid by the insurance company instead of Dr. Katie Tulipano, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

# FINANCIAL POLICY