

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										
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Required Hospitalization Any immune deficiency Tumor or growth on head/neck Image: Constraint of the state of t	Artificial joints				Herpes			Т	onsilitis		
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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			_			
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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