CORTEZ GARDENS FAMILY DENTAL

**PATIENT LAST NAME:** _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

## INSURANCE INFORMATION

| Primary Insurance | Secondary Insurance |
|---|---|
| Subscriber Name _____ | Subscriber Name _____ |
| Subscriber ID _____ | Subscriber ID _____ |
| Date of Birth _____ | Date of Birth _____ |
| Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other | 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 ( ☐Mobile ☐Work ☐Home) _____

## 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 _____ Date _____
*(Responsible Party, if under 18)*

# PATIENT REGISTRATION

CORTEZ GARDENS FAMILY DENTAL

**PLEASE COMPLETE ALL INFORMATION – THANK YOU**

**PATIENT LAST NAME:** _____ **PATIENT FIRST NAME:** _____

## DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

| Please check if you have/had: | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Bad breath | ☐ | ☐ | Head, neck, jaw pain, or aches | ☐ | ☐ |
| Blisters on lips or mouth | ☐ | ☐ | Lip or cheek biting | ☐ | ☐ |
| Burning sensation on tongue | ☐ | ☐ | Loose teeth or broken fillings | ☐ | ☐ |
| Chew on one side of mouth | ☐ | ☐ | Mouth breathing | ☐ | ☐ |
| Cigarette, pipe, or cigar smoking | ☐ | ☐ | Orthodontic treatment | ☐ | ☐ |
| Smokeless tobacco | ☐ | ☐ | Nitrous Oxide | ☐ | ☐ |
| Dry mouth | ☐ | ☐ | Periodontal treatment | ☐ | ☐ |
| Food collection between teeth | ☐ | ☐ | Sensitivity to pressure or irritants | ☐ | ☐ |
| Clench or grind teeth | ☐ | ☐ | (cold, heat, sweets) | | |
| Growths or sore spots in your mouth | ☐ | ☐ | How often do you floss? _____ | | |
| Gums swollen, tender or bleeding | ☐ | ☐ | How often do you brush? _____ | | |

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐Yes ☐No

If Yes, please explain _____

_____

_____

Have you ever had trouble from previous dental care?

☐Yes ☐No If Yes, please explain _____

_____

_____

## MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ _____Blood Pressure_____

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 ☐ 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 | ☐ | ☐ | Headaches | ☐ | ☐ | Slow healing wounds | ☐ | ☐ |
| Anemia | ☐ | ☐ | Heart murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Arthritis, Rheumatism | ☐ | ☐ | Heart problems | ☐ | ☐ | Swelling of feet or ankles | ☐ | ☐ |
| Artificial heart valves | ☐ | ☐ | Hepatitis type _____ | ☐ | ☐ | Thyroid problems | ☐ | ☐ |
| Artificial joints | ☐ | ☐ | Herpes | ☐ | ☐ | Tonsilitis | ☐ | ☐ |
| Asthma | ☐ | ☐ | High blood pressure | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Required Hospitalization | ☐ | ☐ | Any immune deficiency | ☐ | ☐ | Tumor or growth on head/neck | ☐ | ☐ |
| Have you used steroids | ☐ | ☐ | Jaundice | ☐ | ☐ | Ulcer | ☐ | ☐ |
| Date of last episode _____ | ☐ | ☐ | Kidney disease | ☐ | ☐ | Venereal disease | ☐ | ☐ |
| 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 | ☐ | ☐ | Osteopenia | ☐ | ☐ | Are you currently under the care of a Physician? | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Pacemaker | ☐ | ☐ | Are you allergic/sensitive to Latex? | ☐ | ☐ |
| Circulatory problems | ☐ | ☐ | Radiation treatments | ☐ | ☐ | Allergic to Penicillin, Aspirin, or other drugs? | ☐ | ☐ |
| Cortisone treatments | ☐ | ☐ | Respiratory disease | ☐ | ☐ | *If Yes, please specify* _____ | | |
| Cough, persistent or bloody | ☐ | ☐ | Rheumatic fever | ☐ | ☐ | _____ | | |
| Diabetes | ☐ | ☐ | Scarlet fever | ☐ | ☐ | _____ | | |
| Emphysema | ☐ | ☐ | Shortness of breath | ☐ | ☐ | List any medications that you are taking: | | |
| Epilepsy | ☐ | ☐ | Sinus trouble | ☐ | ☐ | _____ | | |
| Fainting | ☐ | ☐ | Sickle cell anemia | ☐ | ☐ | _____ | | |
| Glaucoma | ☐ | ☐ | Skin rash | ☐ | ☐ | _____ | | |

## AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

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 |
|---|---|---|---|---|
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CORTEZ GARDENS FAMILY DENTAL

## SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security 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

I, _____ 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

## 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) Date:

## 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 Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:*

Personal Representative's Name: _____

Relationship to Patient: _____

CORTEZ GARDENS FAMILY DENTAL

**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 *courtesy* 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.***

**Responsible Party Signature** _____ **Date** _____