

Florida Family Dentistry, P.A.

Patient Name: _____
Last First M Preferred Name

Gender: _____ Family Status: _____
M F Married Single Child Other

Birth date: ____/____/____ Social Security #: _____

Email address: _____

Phone: _____
Home Cell Work

Address: _____
Mailing Address Apt#

City State Zip Employer: _____

Emergency Contact, Phone Number and Relationship

Emergency Contact Name	Phone #	Relationship
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New Patients

How did you hear about us? _____

Approximately how long has it been since your last dental examination?

3 months	4 months	6 months	12 months	2+ yrs
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Are you interested in:

___ a whiter smile ___ straighter teeth ___ replace missing teeth

Do you:

___ grind or clench your teeth? ___ have sleep apnea

Is there anything specific you would like to discuss and potentially change about your smile? _____

Florida Family Dentistry, P.A.
4 N Old Kings Road, Ste A. Palm Coast, FL 32137

Do you have a history of taking Bone Density Drugs? Yes _____ No _____

Please list your current medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please highlight your **allergies** below:

Ampicillin	Aspirin	Augmentin	Bactrim
Benadryl	Biaxin	Cipro	Codeine
Flexeril	Ibuprofen	Keflex	Latex
Levaquin	Morphine	Penicillin	Rocephin
Steroid	Sulfa Drug	Tylenol	Amoxicillin
Doxycycline	Azithromycin	Epinephrine	Erythromycin
Luxatemp (dental material)	Medrol Pack		

Please highlight the **medical conditions** that apply to you:

Alzheimer's	Anemia	Anxiety/Depression	Arthritis
Artificial Heart Valve	Artificial Joint	Asperger Syndrome	Asthma/Breathing Issue
Bleeding Issue	Blood Disease	Blood Thinner Drug	Bone Density Drugs
Cancer	Chemotherapy	Chronic Cold Sores	COPD
Covid Exposure w/in 10 days		Crohn's Disease	Defibrillator
Dementia	Diabetes	Drug/Alcohol Addiction	Dry Mouth
Epilepsy	Fibromyalgia	Genetic Syndrome	Gerd (Acid Reflux)
Glaucoma	Growths in mouth	Hard of Hearing	Head Injuries
Heart Attack	Heart Disease	Heart Issue (AFib)	Heart Murmur
Heart Valve Issue	Hepatitis	High Blood Pressure	HIV
Immune System Issue	Kidney Disease	Liver Disease/Issue	Low Blood Pressure
Mitral Valve Prolapse	Organ Transplant	Osteoporosis	Pacemaker
Parkinsons	Persistent Cough	Pregnancy (Currently)	Premed Needed
Radiation Treatment	Respiratory Issue	Rheumatic Fever	Rheumatism
Seizures	Septicemia/Septic	Sexually Transmitted Disease	Sinus Problems
Sleep Apnea	Special Accommodation	Special Needs (i.e.; Autism)	Stomach Problems
Stroke	Surgery (past 5 years)	Syndrome - Explain below...	Thyroid Condition
TMJ/Jaw Problem	Tobacco Use	Trigeminal Neuralgia	Tuberculosis
Vertigo/Dizziness	Visit to ER past 3 years	Visit to Hospital past 3 years	

Florida Family Dentistry, P.A.

Thank you for choosing Florida Family Dentistry, P.A. for your dental needs. Our primary responsibility is to provide you with the best dental care possible. We shall endeavor to make your visits as convenient and pleasant as possible. If you have any questions regarding your treatment, appointment or fees – please feel free to ask.

In order to minimize bookkeeping time and therefore eliminate unnecessary fee increases, ALL PAYMENTS FOR PROFESSIONAL SERVICES ARE DUE AND WILL BE COLLECTED AT THE TIME OF APPOINTMENT.

We offer an in-house savings plan as well as payment plans through Care Credit and Cherry Financing. If you need to discuss our savings plan, your payment method or our billing policy, please speak with our front desk staff.

There will be a **\$10 rebilling charge** for each month a balance remains unpaid. If after three billing cycles pass without payment, your account will then be subject to a monthly late fee equal to 18% APR of the unpaid balance or the \$10 rebilling charge, whichever is greater.

If you need to change your scheduled appointment, we ask you to notify us 24 hours in advance. If you fail to provide 24 hours notice, we will charge a **\$50 cancellation fee**. If you miss 3 or more consecutive appointments, we may consider dismissing you from the practice.

For every returned check, you will be required to pay \$35 to cover bank fees assessed to our practice. As a part of our effort to prevent identity fraud, we make a copy of your driver's license or state issued photo I.D. **We will be unable to write prescriptions, refer you to a specialist or accept a check or credit card without a copy of your driver's license or state issued photo I.D.**

We require yearly updates of your health history information. It is very important we are aware of medications and medical conditions as we treat you as a patient which also enables us to speak on your behalf in the event you were to have a medical emergency.

DENTAL INSURANCE POLICY

Florida Family Dentistry, PA is happy to submit PPO plans however, we are not contracted with any dental insurance companies as we do not feel an insurance company should dictate how we treat our patients. If you have a dental insurance plan that is a **PPO** plan policy, we can generally submit the claims on your behalf. However, please keep in mind the benefits you would be using with our practice would be the benefits listed under **out-of-network** for your plan policy. You will generally pay a bit more out of pocket when choosing to go out of network. If you have an HMO plan, you can only use your insurance plan with dental providers *in-network* which we are not.

With Medicare Supplement plans: We do not accept Assignment of Benefits with Medicare Plans. If you have a dental supplement in addition to your medical coverage and if you have a Dental PPO plan, we can generally submit your claims on your behalf and the reimbursement - if any, will go to you directly. Therefore, you will be required to pay us in full date of service. Some Medicare Supplement plans require the patient submit their own claim. This is dictated by the plan you chose through Medicare.

Please keep in mind we offer an in-office Savings Plan which can save you 25 – 30%+.

Please see our Savings Plan Brochure for details or ask a front desk associate.

Your dental insurance policy is a contract between you and your insurance company; we are not a party to the contract. As a courtesy we will assist you by filing dental insurance claims on your behalf. As dental services are rendered to you, we will estimate as closely as possible your out-of-network dental insurance coverage. However, until we receive payment from the insurance company, we will not know exactly what your insurance company will pay, *if any* towards your treatment. If your dental insurance company payment does not satisfy your account balance in full within 90 days, the remaining balance is your responsibility and must be paid immediately otherwise you will be subject to monthly late fees as stated in our office policy included in our Patient Health History Packet. If you are using your benefits with a specialist, we cannot track your yearly maximum benefits. Therefore, it is your responsibility to determine what you have left to use.

Common Insurance Definitions

1. Annual Maximum Allowance: The maximum amount your dental insurance company will pay towards your dental treatment per year. Exclusions may apply. Once your plan maximum is used up, all additional treatment fees are your responsibility and are due date of service.

2. Assignment of Benefits: This is the term used defining who your dental insurance company will pay directly. In some cases, they will NOT pay an out of network provider directly. In this case, you will pay us in full, we will submit your claims and you will receive whatever your dental insurance company will pay for your treatment we've submitted according to your plan details.

3. Deductible: This is the amount you will pay out of pocket BEFORE ANY of your plan coverage begins to cover your treatment.

4. Exclusions: Explains what your plan does not cover at all.

5. Missing Tooth Clause: If your plan has a missing tooth clause, it will not cover replacement of a tooth that fell out or was extracted prior to your dental insurance coverage with your current insurance provider.

6. Waiting Period: Some insurance companies set a waiting period which means they will not begin coverage until their set date. See your policy for details.

Information we need to enable us the ability to submit your out of network dental insurance benefit claims:

1. Dental Insurance Co Name (*not* your medical info, we must have the Dental Insurance Company name specifically as it may be different from your medical insurance provider). WE CANNOT USE YOUR MEDICAL INSURANCE INFORMATION. It is your responsibility to provide your dental insurance information.
2. The Subscriber's Name and Date of Birth
3. The Patient's Name and Date of Birth(if you are listed under someone else's policy. They would be the "subscriber")
4. The Subscriber or Member # or the Social Security Number of the Subscriber
5. The Group # or Plan # (if available)
6. The Employer's name (if applicable) or group name if available
7. The phone # of the Dental Insurance Company (typically found on the back of the card)

We are not able to make a phone call to acquire your benefits without **ALL** the above information. If you do not have this information, please call your HR Manager or insurance carrier to access the information. Most of the time, insurance carriers require patients to retrieve insurance cards online.

Even if you do not currently have insurance, it is possible you may in the future. Please sign and date below indicating you understand our insurance policies.

Please sign and date below indicating you have read and agree to our insurance submittal policy.

Signature

Date

Health information consent :

Please initial, sign and date as indicated below:

I have read and I agree with Florida Family Dentistry's terms stated in this Health History Packet.

Initials

I have received a Notice of Privacy Policy (HIPPA) form from Florida Family Dentistry, refer to page 8 in this Health History Packet.

Initials

Patient Name (print): _____

Patient Signature: _____

Date: _____

If applicable: I consent to dental treatment of a minor child listed as "Patient".

Name of minor patient: _____ **Relationship:** _____

Date: _____ **Guardian Name:** _____

Guardian Signature: _____

Florida Family Dentistry, P.A. Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTIES

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect 04/14/2003 and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example: **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. **Payment:** We may use and disclose your health information to obtain payment for services we provide to you. **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. **Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare purpose, if you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. **Persons Involved in care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. **Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization. **Required By Law:** We may use or disclose your health information when we are required to do so by law. **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officer having lawful custody of protected health information of inmate or patient under certain circumstances.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the formation you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page copies, and \$5.00 per x-ray duplicated and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure. **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests. **Restrictions:** You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request. **Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. **Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S., Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Christina Santopadre, Office Manager
Telephone: (386) 445-1234
Fax: (386) 447-4000
Address: 4 N. Old Kings Rd., Suite A Palm Coast, FL 32137

2002 American Dental Association

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