Palm Coast Family Dentistry
50 Cypress Point Pkwy. Ste. A-3-A4, Palm Coast, FL 32164
Phone: (386) 445-0977 Fax: (386) 445-0579

Patient Information

Patient Name: _____ Date: _____
Last, First MI

I prefer to be called _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Widowed ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Friend ☐ Google ☐ Insurance

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Spouse Information

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Employer: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ Group #: _____
Last First MI

Insured's Birth Date: _____ SS#: _____ ID #: _____

Name of Insurance: _____ Insurance Co Phone # _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

I authorize the use of my study models and/or photographs for lectures or publications by Dr. Sandra Trejos, DDS or Dr. Pratik Patel, DMD.

_____ Date: _____
Signature of patient, parent or guardian

FINANCIAL POLICIES/INFO FOR OUR PATIENTS

Appointments:
Our appointments are scheduled to respect your time. We reserve a specific time for your care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change an appointment, a 48-hour notice is expected.

Payment Options:
For your convenience, we accept Visa, MasterCard, Discover, American Express and personal checks. Our extended payment plan is available through Care Credit.

Missed/Broken Appointments:
Once an appointment has been made, a room is reserved, your records are prepared, special instruments are readied for your visit, and most importantly, a specific slot of time is held for you. Because of this, we ask that you give us a 48-hour business day notice when changing any appointment in order to avoid a broken appointment charge, which ranges between $30 and $75. We feel that our patient's time is valuable and we try our best to be prompt. We, of course, would appreciate the same courtesy from you.

Dental Insurance:
We are glad to assist you with your dental insurance plan. To help us assist you in obtaining your maximum benefit, please bring your insurance card. Once Insurance plan coverage has been verified, we will accept assignment of payment from your insurance company. Most plans cover only a portion of the dental fee, which means you will be responsible for your deductible and any portion we estimate your plan will not cover. Payment of you estimated portion is expected at the time you are in our office for dental care, unless prior arrangements have been made. Any balance remaining after the claim has been processed is patient responsibility.

Understanding dental insurance can be challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different with lower premium plans covering fewer services, downgrading of services and lower fees for services. We encourage you to become familiar with your policy exclusions, deductibles and limitations.

Our courtesy service to you includes:
1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of benefits available to you.
4. Re-filing your insurance a second time at 30 days and a final time at 45 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:
1. Payment of fees not covered by your insurance plan at the time the service is delivered. 2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Taking responsibility for payment if the insurance company does not pay our office within 60 days.
4. Keeping our office informed of any changes in your insurance coverage or employment.

To assist us in obtaining your benefits, please sign the "assignment of benefits" below to allow us to file your insurance claims. Also, please have your insurance card and photo ID ready for us to copy for our file.

I understand that this Pre-Authorization Consent is valid through the dates stated above unless I cancel the authorization through written notice.

I hereby authorize Dr. Patel or Dr. Trejos to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Patel or Dr. Trejos. I understand I am responsible for any unpaid balance.

Patient Name & Signature_____ Date: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Palm Coast Family Dentistry Notice of Privacy Practices, which has an effective date of 09/23/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Patient's Representative Date

_____
Print Name

_____
Relationship to Patient (If not signed by the Patient)