PERSONAL HISTORY

Confidential

PLEASE PRINT

Date _____

Patient Name _____
Last First Middle

Address _____
Street City State ZipCode

Social Security Number _____ Sex M F

Birth Date _____ Marital Status S M W D

If minor, name of parent or guardian _____

Home Phone ( ) _____ Work Phone ( ) _____

Alternate Phone ( ) _____

Employer Name _____

Employer Address _____

I understand that I am financially responsible for all charges.

_____
Signature of Patient / Parent or Guardian if minor

INSURANCE

Your insurance is a method for you to receive reimbursement for the fees you have paid. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on the contract you have with them, not with our office. It is your responsibility to pay deductible, co-insurance, and any other balances not paid for by your insurance. We will do all we can to assist you in receiving reimbursement, but you are responsible for your bill.

Dental Insurance Company _____ Phone _____

Policy Holder _____ Patient's Relationship to Policy Holder _____

Policy Holder's Social Security Number _____ Policy Holder's DOB _____

Policy Holder's Employer / Group Name _____ Group # _____

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims.

I hereby authorize payment directly to Dental Specialty Group of Pinellas and named dentist.

_____ _____
Signature of Patient / Parent or Guardian if minor Date

MEDICAL HISTORY

Personal Dentist _____ Phone _____

Personal Physician _____ Phone _____

_____

Age _____ Height _____ Weight _____

Do you smoke? Y N If yes, how much? _____

Do you drink alcohol? Y N If yes, how much? _____

Do you have a history of or problems with:

A recent weight change	Y	N	Heart disease	Y	N
Excessive thirst	Y	N	Angina or chest pain	Y	N
Diabetes	Y	N	Liver disease	Y	N
Cuts which have not healed	Y	N	Hepatitis	Y	N
Stroke	Y	N	Anemia	Y	N
Dizzy spells	Y	N	Do you have a bleeding tendency	Y	N
Shortness of breath	Y	N	Excessive bleeding	Y	N
Lung disease	Y	N	High blood pressure	Y	N
Asthma	Y	N	Thyroid disease	Y	N
Bronchitis	Y	N	Tuberculosis	Y	N
Frequent cough	Y	N	Stomach pain	Y	N
Drug abuse	Y	N	Kidney disease or infection	Y	N
AIDS	Y	N	Glaucoma	Y	N
Hay Fever	Y	N	Do you wear contact lenses	Y	N
Sinus problems	Y	N	Seizures	Y	N
Rheumatic Fever or heart murmur	Y	N	Are you pregnant	Y	N
Scarlet Fever	Y	N	Have you donated blood lately	Y	N

How often do you take aspirin? _____

Have you ever had I.V. sedation? _____

What other serious illnesses or injuries have you had? _____ None

_____

What operations or surgeries have you had? _____ None

_____

What medicine or pills are you taking now? _____ None

_____

What medication(s) are you allergic to? _____ None

_____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE.

To the best of my knowledge, all of the preceding answers are true and correct.

_____ _____

Signature of person completing health history Date

You will have an opportunity to discuss your health history with the doctor.

_____

DR.'s initials

Dental Specialty Group of Pinellas
4326 Park Boulevard, Suite C-East
Pinellas Park, FL 33781
(727) 544-5345

CANCELLATION / MISSED APPOINTMENT POLICY

Our office strives to provide optimum treatment and convenience for our patients by offering several specialties in one location. This means however, that each specialist is available only certain days.

Therefore, we ask that you help us by keeping your scheduled appointments, and by notifying our office in advance if you are unable to do so.

We have a waiting list for appointments and when given advance notice we are often able to accommodate other patients.

ALL PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDULED APPOINTMENTS OR WHO CANCEL WITH LESS THAN 24 HOURS ADVANCE NOTICE WILL BE CHARGED A MISSED APPOINTMENT FEE

- Missed appointment fees are **NOT** covered by insurance plans and are your responsibility to pay
- If you need to cancel or reschedule an appointment, please give at least **24 hours** notice to avoid a charge
- If you fail your appointment and have not notified the office 24 hours in advance you will be charged a missed appointment fee
- If you miss two consecutive appointments, any remaining appointments scheduled will be cancelled and referring dentist will be notified.

Thank you for your cooperation.

Patient Name (please print): _____

Signature below indicates I have read and understand this policy.

Patient(18 or older) or Legal Guardian Signature: _____

INSURANCE BENEFIT ACKNOWLEDGEMENT

Your insurance is a method for you to receive reimbursement for the fees you have paid. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on the contract you have with them, not with our office. It is your responsibility to pay deductible, coinsurance, and any other balances not paid by your insurance company.

In determining the amount of benefits payable, your insurance company may give consideration to an alternate procedure that may accomplish a professional satisfactory result. If an alternate benefit provision is applied to a procedure performed by your dentist and submitted to your insurance company as a claim, the amount of money you owe your dentist may be more than the amount specified on the Explanation of Benefits (EOB).

Estimates of coverage are not a guarantee as eligibility, policy provisions and possible charges from other offices affect payment. Your insurance company may not pay their full estimated portion. YOU ARE RESPONSIBLE FOR ALL TREATMENT CHARGES NOT PAID BY YOUR INSURANCE COMPANY.

I agree to pay the fees, including any deductible, co-insurance, and any other balances not paid by my insurance company, to Dental Specialty Group of Pinellas.

_____ _____

Signature of Patient/ Legal Guardian if patient is minor Date

_____

Patient's Name

Dental Specialty Group of Pinellas

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose**: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.**

****You May Refuse to Sign This Acknowledgement****

I have been given copy of this office's Notice of Privacy Practices to review and I am aware that the office has a copy of the Notice available to take with me if I request one.

_____

{Please Print Patient's Name}

_____

{Signature of Patient or Legal Guardian}

_____

{Date}

Dental Specialty Group of Pinellas may use or disclose protected health information for the purpose(s) of treatment, payment, collections, or health care operations. We may disclose your personal health care information to other dental and/or medical professionals relating to your treatment, payment, or health care. If you wish to authorize Dental Specialty Group of Pinellas to release your personal health care information to anyone other than for the reasons above, please list below.

1. _____
2. _____
3. _____

For Office Use Only

We attempted to obtain written proof of Informed Acknowledgement of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____

_____

_____