Teeth R' Us Dental Design Center Inc

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU – THANK YOU

Date _____

PATIENT LAST NAME_____ **FRIST**_____ **INITIAL**_____

Birthdate_____ Social Security #_____

(☐Single ☐Married ☐Divorced) (☐Male ☐Female) Full Time Student? ☐Yes ☐No School_____

Address _____

City_____ State_____ Zip_____

Telephone (home)_____ Mobile_____ Work_____

Email_____

Employer_____ Occupation_____

Soc. Sec. No._____ Dental Insurance Co._____

Is patient covered by another dental insurance? Yes_____ No_____ Insurance Co. _____

How did you hear about us? Whom may we thank for the referral?_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Last Name_____ first Name_____ Initial_____

Address_____ DOB_____

City_____ State_____ Zip_____

Telephone (home)_____ Mobile_____ Work_____

Email_____

Employer_____ Occupation_____

Soc. Sec. No._____ Dental Insurance Co._____

NEAREST RELATIVE- EMERGENCY CONTACT

Last Name_____ first Name_____ Initial_____

Address_____ DOB_____

City_____ State_____ Zip_____

Telephone (home)_____ Mobile_____ Work_____

INSURANCE INFORMATION

Dental Insurance Company Name_____ Telephone # _____

Policy #_____Group #_____

Name of Policy Holder_____ Insured Name_____

Insured Social Security #_____ Insured Birthdate_____

Employer_____ Relationship to Patient_____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dental office, otherwise payable to me. I understand that my dental carrier or payer of my dental benefits **may pay less** than the actual bill for services.

I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature_____ Date_____

PATIENT REGISTRATION

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PATIENT NAME_____ **DATE:**_____

Teeth R' Us Dental is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about fees, Financial Policy, or your responsibility.

- **ALL PATIENT MUST COMPLETE OUR " PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL**
- **FULL PAYMENT IS DUE AT THE T IME OF SERVICE.**
- **WE ACCEPT CASH, VISA, MASTER CARD, DISCOVER, AND CARE CREDIT.**
- **TEETH R'US DENTAL PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINOR 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 Visa, Master Card or Discover. We do not accept Care Credit payments for visits by unaccompanied minors.

INSURANCE

Teeth R'Us Dental provides 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 Teeth R' Us Dental staff 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 Teeth R' Us Dental. However, if you are paid by the insurance company instead of Teeth R' Us Dental, 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.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balanced after the balance has been outstanding 30 days.

MISSED APPOINTMENTS

Unless appointments are cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $35.00. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature_____ **Date**_____

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SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By using 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 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 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 Practiced. 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 our protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions to our Notice, at any time by contacting our office: **Teeth R' Us Dental**
Telephone: 305-974-5175
Address: 17560 NW 27 Avenue Ste 101 Miami Gardens, FL. 33056

Right to Revoke: You will have the right to revoke this Consent at any time giving us written notice of revocation submitted to our office 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 and the treatment, payment activities, and health 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

CONSENT FORMS/ PRIVACY PRACTICES RECEIPT

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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 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 Teeth R' Us Dental to disclose and discuss my protected health information to carry out treatment, payment activities and healthcare 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 notices of your revocation submitted to the Office Manager listed on Section B.

_____ _____
Patient Signature (Legal Guardian, if Patient is a minor) Date

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Teeth R' Us Dental Design Center to 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: _____

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PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME_____ **PATIENT FIRST NAME**_____

DENTAL HISTORY

Reason for today's visit: _____ Date of last dentist visit_____

Former dentist:_____ Date of last dental x-rays_____

Are you currently in pain? Y N Do you require antibiotics before dental treatment? Y N

Do you now or have ever experienced pain/discomfort in your jaw joint (TMJ/TMD)

Your current dental health

Type of bristles on your toothbrush? S M H How long do you use a toothbrush before replacing it?_____

Would you like fresher breath?_____ Whiter teeth_____

PLEASE CHECK IF YOU HAVE/HAD

Bad breath	☐	Gums swollen, tender, or bleeding	☐	Have you ever had allergic reaction	☐
Blisters on lips or mouth	☐	head, neck, or jaw pain or aches	☐	to Novacaine, local or general	
Burning sensation on tongue	☐	Lip or cheek biting	☐	anesthetics?	
Chew on one side of mouth	☐	Loose teeth or broken fillings	☐	If Yes please explain	
Cigarette, pipe or cigar smoking	☐	Mouth breathing	☐	_____	
Smokeless tobacco	☐	Orthodontic treatment	☐		
Dry mouth	☐	Nitrous Oxide	☐	Have you had trouble from previous	
Food collection between teeth	☐	Periodontal treatment	☐	dental care?	
Grind teeth	☐	Sensitivity to pressure or irritants	☐	If Yes, explain what happened	
Growths or sore spots in mouth	☐	Sensitivity to cold, heat, sweets	☐	_____	
Clench teeth	☐	How often do you floss? _____		_____	
		How often do you brush? _____			

MEDICAL HISTORY

Physician's name: _____Date of last visit _____

Physician's address: _____

City_____ State:_____ Zipcode:_____ Ph #: _____

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: _____

Have you had any serious illnesses or operations? ☐ If Yes, please give approximate dates:_____

Pregnant? Yes ☐ Due Date?_____ Nursing? Yes ☐ Birth Control Pills? Yes ☐

Are you taking any of the following?

Acetaminophen	Y	N	Blood Pressure Medication	Y	N	Insulin/ Diabetic Drugs	Y	N
Antibiotics	Y	N	Cold Remedies	Y	N	Nitroglycerin	Y	N
Antihistamines	Y	N	Digitalis/ Heart Medication	Y	N	Recreational Drugs	Y	N
Aspirin	Y	N	Thyroid Medicine	Y	N	Steroids/ Cortisone	Y	N
Blood Thinners	Y	N	Tranquilizers	Y	N			

Are you taking any prescription, over the counter drugs, herbal remedies, vitamins or minerals not listed above?

Y ☐ N ☐ If Yes, please list each one:_____

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Please check if you or have you experienced the following

Abnormal Bleeding	☐	Cough persistent	☐	High Blood Pressure	☐	Shingles	☐
Alcohol Abuse	☐	Diabetes	☐	HIV/AIDS	☐	Shortness of Breath	☐
Allergies	☐	Difficulty Breathing	☐	Jaundice	☐	Sickle Cell Disease	☐
Anemia	☐	Emphysema	☐	Kidney Problems	☐	Skin Rash	☐
Arthritis	☐	Epilepsy	☐	Low Blood Pressure	☐	Steroid Therapy	☐
Artificial Bones/Joints	☐	Fainting	☐	Lupus	☐	Stroke	☐
Artificial Heart Valve	☐	Fever Blisters	☐	Mitral Valve Prolapsed	☐	Swelling of Feet	☐
Asthma	☐	Glaucoma	☐	Osteopenia	☐	Thyroid Problems	☐
Blood disease	☐	Hay Fever	☐	Osteoporosis	☐	Tonsillitis	☐
Cancer	☐	Headaches	☐	Pacemaker	☐	Tuberculosis Cell Disease	☐
Chemotherapy	☐	Heart Attack	☐	Psychiatric Problems	☐	Tumor or Growth on Head/Neck	☐
Chicken Pox	☐	Heart Murmur	☐	Radiation Treatments	☐	Ulcer	☐
Circulatory Problems	☐	Heart surgery	☐	Respiratory Disease	☐	Venereal Disease	☐
Colitis	☐	Hemophilia	☐	Rheumatic Fever	☐	Weight Loss Unexplained	☐
Congenital Heart defect	☐	Hepatitis	☐	Scarlet Fever	☐		
Cortisone treatments	☐	Herpes	☐	Seizures	☐		

AUTHORIZATION AND RELEASE

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

Patient/Guardian Signature_____Date:_____

Review by:_____ Date:_____

DENTAL & MEDICAL HEALTH HISTORY