## Patient Information

Date: _____

Daytime Phone (___) _____ Cell Phone (___)_____

Full Name _____ Birthdate _____

Address _____ SS # _____

City _____ State_____ Zip _____

Northern Address _____ In Florida how many months?____

Sex: ☐Male ☐ Female ☐ Married ☐ Widowed ☐ Single ☐ Child

Patient Employer _____Employer Phone: (___)_____

Whom may we thank for referring you? _____

Are any of your family members already patient's here? ☐Yes ☐No

If yes, name of family member _____

Payment Method? ☐Cash ☐Check ☐ Credit Card ☐ Care Credit

In case of an emergency who should be notified?_____

Emergency Contact Person's Phone Number (___) _____

## Primary Insurance

Person Responsible for Account Last Name _____ First Name _____ M.I._____

Relation to Patient _____ DOB _____SS# _____

Address (if different from patient's) _____ Phone (___) _____

City _____ State_____ Zip _____

Person Responsible Employed By _____ Occupation_____

Business Address _____Business Phone (___) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber #_____

Names of other dependents covered under this plan _____

_____

## Additional/ Secondary Insurance

Is patient covered by additional dental insurance? ☐Yes ☐No

# Medical History

**Patient's Name** _____

Physician's Name _____

Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

**Check if you have or have had any of these conditions :**

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Cortisone Treatment | ☐ Hepatitis | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough up Blood | ☐ HIV/AIDS | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Thyroid Problems |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Tobacco Habit |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tonsillitis |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Ulcer |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Venereal Disease |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | ☐ Congenital Cardiac Malformations |
| ☐ Osteoporosis | | | |

## MEDICATIONS

**List medications you are currently taking:**

_____

_____

_____

_____

## ALLERGIES

_____

_____

_____

_____

Doctor's Signature_____ Date _____

# Smile Evaluation

By filling out this Smile Evaluation, our team will be able to help you obtain the smile you have always wanted. Please feel free to discuss with our staff any questions or areas of concern. This allows our practice to maintain our focus and time spent on the delivery of the best quality of dental care.

Name: _____ Date: _____

| | | | |
|---|---|---|---|
| Are you pleased with the appearance of you teeth when you smile? | | ☐ Yes | ☐ No |
| Are you pleased with the color of your teeth? | | ☐ Yes | ☐ No |
| Are you pleased with the shape of your teeth? | | ☐ Yes | ☐ No |
| Are you pleased with the appearance of your gums when you smile? | | ☐ Yes | ☐ No |
| Are your gums puffy, red or swollen looking? Do they bleed easily? | | ☐ Yes | ☐ No |
| Do your old fillings still please you? | | ☐ Yes | ☐ No |
| Are your teeth: | Chipped? | ☐ Yes | ☐ No |
| | Protruding? | ☐ Yes | ☐ No |
| | Crowded? | ☐ Yes | ☐ No |

If you would like to change anything about the appearance of you smile what would that be?

_____

_____

_____

_____

## Check if you have problems with any of the following:

| | | |
|---|---|---|
| ☐ Bad Breath | ☐ Sores or growths in mouth | ☐ Sensitivity to hot |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Periodontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Grinding teeth | ☐ Sensitivity to cold |

# ACKNOWLEDGEMENT OF RECEIPT
# OF
# NOTICE OF PRIVACY PRACTICES

A copy of our Notice of Privacy Practices is available upon request.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices, and either, have read or declined to read them.

This form will remain in my patient chart.

_____ _____

Print Name Date

_____

Signature

NORTH PORT DENTAL

**Agreement to Receive Electronic Communication**

Patient Name:_____ Date of Birth:_____

***Please read the following statement and initial accordingly:***

That the dental practice may communicate with me electronically at the email address and /or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

I_____ DO AGREE

I_____ DO NOT AGREE

***Please complete the following section <u>ONLY</u> if you've agreed to the above terms.***

***Initial below to indicate your preferred method of communication***

_____ Phone call

_____ Text Messaging

_____ Email

I would like to receive:

_____ Appointment Reminders/Recall Visits

_____ Information regarding insurance/billing

_____ Requests for Patient Satisfaction online reviews

*Please be advised you can withdraw your consent to receive electronic communications at any time by calling us at (941) 426-8289 or by emailing northportdental@gmail.com*

Patient Signature:_____ Date:_____

14884 TAMIAMI TRAIL • NORTH PORT COMMONS
NORTH PORT, FL 34287
PHONE: (941) 426-8289• FAX: (941)426-8726

# FINANCIAL POLICY FOR NORTH PORT DENTAL

We are committed to providing you with the best possible dental care. We try to be up front and transparent about all fees pertaining to your recommended treatment. Please feel free to ask us at any time if you have any questions or concerns about paying for your dental care. Your clear understanding of our financial policies is important to our professional relationship.

## INITIAL VISIT

Dental x-rays will be required in most cases, in order to provide a proper diagnosis of your dental health. Please check that your referring dentist(s) has shared all current x-rays with our office, prior to your appointment.

## DENTAL INSURANCE FILING

If you have dental Insurance, we will assist you by processing all dental insurance claims. It is the patient's responsibility to understand their insurance benefits and out-of-pocket expenses. As a courtesy, we process your dental claims and pre-treatment estimates. A pre-treatment estimate from your insurance company is not a guarantee of coverage. The guarantor is personally liable for all balances not covered by dental insurance. Please be aware that we cannot submit any medical insurance claims. All correspondence with medical insurance is the patient's responsibility. If you contact your medical insurance about possible medical benefits, we can assist you with dental treatment codes and x-rays.

## ASSIGNMENT OF BENEFITS

I authorize the release of any information relating to insurance claims by North Port Dental & hereby authorize payment directly to North Port Dental if applicable. I understand that I am financially liable to North Port Dental for charges not covered by my insurance company.

## PAYMENTS

Payments are required at time of treatment. For insured patients, we collect a down payment that varies by treatment needed. We discuss these fees with you before treatment. If insurance has provided us with a pre-treatment estimate, we will collect the full patient responsibility amount stated by insurance at time of service. We accept cash, check, Visa, Master Card, Discover, American Express, and Care Credit.

## CARE CREDIT

North Port Dental accepts payment through Care Credit. Care Credit is an interest-free credit card program, pending credit approval by application to Care Credit. Please contact our office to review this program or visit www.carecredit.com.

## PAST DUE ACCOUNTS

Finance charges will be imposed on accounts beginning 90 days from the date of the initial billing statement. We charge a monthly 1.5% service charge on all past due accounts until they are paid in full. Overdue accounts will be referred to a collection agency and any legal fees, costs or court fees that apply will be added to your account and become the patient's responsibility.

## DIVORCE SITUATIONS

The parent who brings the child in for care will be considered the responsible party and will receive all billing statements and letters. Any court-ordered financial arrangements must be worked out between the parents of the children.

## MISSED APPOINTMENTS

Specific time has been reserved for your treatment with our office. Therefore, we request advance notification of cancellations. If necessary, to cancel your appointment, please notify us at least 24 hours in advance to help serve our patients better. Patients 15 minutes late for a scheduled appointment may need to be rescheduled. For late cancellations/ missed appointments, a $50 charge will be applied to your account.

I understand and will comply with the above financial policies of North Port Dental.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Name (Print): _____