Florida Family Dentistry, P.A.

4 N Old Kings Road Suite A Palm Coast, Florida 32137 #386-445-1234

Patient Name: _____ _____ ___ _____
Last First M Preferred

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

Birth Date: _____/_____/_____ **Social Security #:** _____- _____- _____

Email Address: _____

Phone: _____ _____ _____ ____
Home Cell Work Ext

Address: _____, _____
Mailing Address Apt#

_____, _____ _____ **Employer:** _____
City State Zip

Emergency Contact Name, Phone Number and Relationship:
_____

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.

Are you interested in having a whiter Smile? ----------Yes No
Would you like straighter teeth? ----------Yes No
Are you interested in replacing any missing teeth? ---------- Yes No
Is there anything you would like to change about your smile? -- Yes No
Do you clench or grind your teeth? ----------Yes No
Do you snore or have sleep apnea? ---------- Yes No

Please List your medications:

PLEASE CHECK ALL THAT APPLY

☐ Allergy - Ampicillin	☐ Allergy - Aspirin	☐ Allergy Augmentin	☐ Allergy - Bactrim
☐ Allergy - Benedryl	☐ Allergy - Biaxin	☐ Allergy - Cipro	☐ Allergy - Codeine
☐ Allergy - Flexeril	☐ Allergy - Ibuprofen	☐ Allergy - Keflex	☐ Allergy - Latex
☐ Allergy - Levaquin	☐ Allergy - Morphine	☐ Allergy - Penicillin	☐ Allergy - Rocephin
☐ Allergy - Steroid	☐ Allergy - Sulfa Drug	☐ Allergy - Tylenol	☐ Allergy - Amoxicillin
☐ Allergy - Doxycycline	☐ Allergy - Azithromycin	☐ Allergy - Epinephrine	☐ Allergy - Erythromycin
☐ Allergy - Luxatemp	☐ Allergy - Medrol Pack	☐ 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 Exp. w/in 10 days	☐ Covid - Previously
☐ Crohns 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 Trans. Dis.	☐ Sinus Problems	☐ Sleep Apnea	☐ Special Accomodation
☐ Stomach Problems	☐ Stroke	☐ Surgery (past 5 years)	☐ Syndrome -Explain below
☐ Thyroid Condition	☐ TMJ/Jaw Problem	☐ Tobacco Use	☐ Trigeminal Neuralgia
☐ Tuberculosis	☐ Vertigo/Dizziness	☐ Visit to the ER past 3 yrs	☐ Hospital Visit past 3 yrs

If you do not have any of the above listed Medical Conditions, please initial here: _____

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 several Florida Family Dentistry Savings Plans as well as payment plans through Care Credit. If you need to discuss our savings plans, your payment 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 three billing cycles pass without payment, your account will 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 show for three (3) scheduled appointments, you may be dismissed from the practice.

For every returned check, you will be required to pay $35 to cover bank fees assessed to Florida Family Dentistry, P.A. **As a part of our effort to prevent identity fraud, we make a copy of your driver's license or photo ID. 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 photo ID.**

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 Benefit 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 your 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 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.

*Additionally, if you are able to, take a picture of the front and back of your insurance card(s) and driver's license and text it to us at: 386-445-1234

Please sign here indicating you have read and agree to our Insurance submittal policy

_____ date: _____

I have read and I agree to Florida Family Dentistry's terms stated above on **pages 3, 4 & 5**.

_____

Initial

I have received a Notice of Privacy Policy (HIPPA) from Florida Family Dentistry on **page 7**.

_____

Initial

Patient Name (print):_____

Patient Signature:_____

Date:_____

If applicable, I consent to treatment of a **minor**.

_____ _____ _____

Name of minor Relationship Date

If you are more than 15 minutes late for your appointment, it may be necessary to reschedule.

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 if important to us.

OUR LEGAL DUTES

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 judgement 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**