BAY DENTAL CENTER

Dr. John C. Collias DDS

Dental Registration and History

PATIENT INFORMATION:

Patient Name_____DOB_____

Address_____ City_____ State_____ Zip Code_____

Cell Phone # (_____) _____-_____ Best Alternate # (_____) _____-_____

SS # _____-_____-_____ Patient: SELF or MINOR ... If minor list Responsible Party below.

Responsible Party _____ DOB _____ SS # _____-_____-_____

Email _____ Male or Female Age _____

Spouse Name _____ DOB _____ SS # _____-_____-_____

Employer Name/Address/Phone # _____

Emergency Contact Name/#/Relationship _____

Whom may we thank for referring you? _____

DENTAL INSURANCE INORMATION:

Dental Insurance Company Name _____

Subscriber Name _____DOB _____ SS # _____-_____-_____

Member ID # _____ Group _____ Relationship to Patient _____

Assignment and Release: I certify that I and/or my dependents have Dental Insurance coverage with the company listed above. Also, that Dr. Collias will provide me with my treatment plan and associated fees. I agree to be responsible for all charges for dental services and material not paid by my dental benefit plan, unless prohibited by law or the treating dentist/practice has a contractual agreement with my plan prohibiting al or a portion of such charge. I consent to your use and disclosure of my protected health insurance information to carry out payment activities in connection with any claims.

Signature: _____ Relationship to Patient: _____

DENTAL HISTORY:

Reason for today's visit _____ Last dental visit_____ Please mark below:

Bad breath____ Bleeding Gums ___ Blister on lips/mouth ___ Burning sensation on tongue ___ Dry Mouth ____
Chew on 1 side of mouth ____ Cigarette/Pipe/Cigar smoker ____ Clicking/Popping ____ Fingernail biting____
Food Collection between teeth ___ Foreign objects ___ Grind Teeth ___ Gums swollen/tender ___ Jaw Pain/TMJ ___
Lip/Cheek biting __ Loose tooth/teeth ___ Broken Fillings ___ Mouth breathing ___ Orthodontic treatment ____
Pain around ear _____ Periodontal treatment ____ Sensitivity to cold/heat ____ Sensitivity to sweets ____
Sensitivity when biting ___ Sores or growths in mouth ___ How often do you: Floss_____ Brush _____

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HEALTH HISTORY:

Please mark "Yes" or "No" below to indicate if you have/had any of the following:

AIDS/HIV	Yes___ No___	Epilepsy	Yes ___No___	Rheumatic Fever	Yes ___No___
Anemia	Yes___ No___	Fainting/Dizziness	Yes ___No___	Scarlet Fever	Yes ___No___
Arthritis/Rheumatism	Yes___ No___	Glaucoma	Yes ___No___	Shortness of Breath	Yes ___No___
Artificial Heart Valves	Yes___ No___	Headaches	Yes ___No___	Sinus Trouble	Yes ___No___
Artificial Joints	Yes___ No___	Heart Murmur	Yes ___No___	Skin Rashes	Yes ___No___
Asthma	Yes___ No___	Heart Problems	Yes ___No___	Special Diet	Yes ___No___
Back Problems	Yes___ No___	Hepatitis	Yes ___No___	Stroke	Yes ___No___
Bleeding w/ extractions	Yes___ No___	Herpes	Yes ___No___	Swollen feet/ankles	Yes ___No___
Blood disease	Yes___ No___	High Blood Pressure	Yes ___No___	Swollen neck glands	Yes ___No___
Cancer	Yes___ No___	Jaundice	Yes ___No___	Thyroid Problems	Yes ___No___
Chemical Dependency	Yes___ No___	Jaw Pain	Yes ___No___	Tonsillitis	Yes ___No___
Chemotherapy	Yes___ No___	Kidney Disease	Yes ___No___	Tuberculosis	Yes ___No___
Circulatory Problems	Yes___ No___	Liver Disease	Yes ___No___	Tumor Head/Neck	Yes ___No___
Congenital Heart Issues	Yes___ No___	Low Blood Pressure	Yes ___No___	Ulcers	Yes ___No___
Cortisone Treatment	Yes___ No___	Mitral Valve Prolapse	Yes ___No___	Venereal Disease	Yes ___No___
Cough,persisten/blood	Yes___ No___	Nervous Problems	Yes ___No___	Weight Loss	Yes ___No___
Diabetes	Yes___ No___	Pace Maker	Yes ___No___	Have you taken Fosamax or any other	
Emphysema	Yes___ No___	Psychiatric Care	Yes ___No___	nitrogen w/ Bisphosphonates?	
Contact Lenses	Yes___ No___	Respiratory Disease	Yes ___ No___		Yes ___ No___

Women: Pregnant Yes ___No___ Due Date _____ Nursing Yes ___ No___ Taking birth control Yes ___ No___

MEDICATIONS

List any medications you are currently taking
And diagnosis:

_____

_____

_____

ALLERGIES

___ Aspirin ___ Barbiturates (sleeping pills)
___ Codeine ___ Iodine
___ Latex ___ Local Anesthetic
___ Penicillin ___ Sulfa

Please list any other medications or allergies not listed _____

Physcician's Name and #_____ Preferred Pharmacy _____

Patient's Signature _____ Date_____ Dentist's Signature _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received and/or have access to a copy of this office's Notice of Privacy Practices:

Name _____ Signature _____ Date _____

Rate your Smile
With 10 being the best
1 2 3 4 5 6 7 8 9 10
HELP--------PERFECT

What would you like to improve about your Smile? Check all that apply.

___ I would like whiter, brighter teeth ___ I would like to straighten my teeth
___ I would like to get rid of gaps between my teeth
___ I would like to repair chipped or broken teeth
___ I would like to replace missing teeth ___I would like to improve my oral health

BAY DENTAL CENTER

Dr. John C. Collias DDS

45 East Beach Drive Panama City, FL. 32401 850-785-5502

Welcome to our office! We are so pleased you have chosen us to be your dental provider.

Office Guidelines & Policies:

We are here to serve our patients! Please read the following and initial that you understand each one.

If you have dental insurance, please CAREFULLY read the following and initial.

Insurance:

INITIAL_____ Insurance claims are always an **"ESTIMATE"**

INITIAL_____ We have gone to great lengths to establish what your insurance benefits are prior to your appointment. However, what insurance states it will cover and what it actually covers are often different. We ask that the estimated portion of your visit is paid at the time of service with the understanding that if the insurance company changes or reduces the amount they will pay for your service; the balance becomes your responsibility.

INITIAL_____ If you would prefer to postpone treatment until a pre-treatment estimate can be obtained from your insurance company for any procedures, please discuss it with us before scheduling your appointment. It can take up to 6 weeks for your insurance company to respond.

INITIAL_____ Your insurance claims will be sent the same day services are rendered. We will make EVERY effort to collect from your insurance company. If your insurance has not provided payment within 30 days, any unpaid balance becomes the patient's responsibility.

INITIAL_____ Payment options are available through Care Credit, a flexible payment plan that specializes in dental care. Please ask for a Care Credit brochure for additional information.

Photographic Releases:

INITIAL_____ In our office, photographs may be taken of our patients for aid in determining proper diagnosis and to help visualize with the appropriate treatment options. I understand that the photographs will be used in a record of my care and may be used for educational purposes.

Missed Appointments:

INITIAL_____ We do not over book the schedule and our appointment time is reserved exclusively for you. We commit to respecting your time and all we ask is that you give us 2 business day notice prior to relocating your appointment. Please keep in mind our business week is Monday thru Thursday. All missed appointments with less than 24-hour notice will incur a $25 dollar fee.

Late Arrival:

INITIAL_____ If you plan to be more than 5 minutes late for an appointment, kindly give us a call to be sure that we can accommodate you.

Interest/Collection fees:

INITIAL_____ We reserve the right to charge interest in the amount of 9.9% monthly on extended payment plans and accounts over 30 days past due as allowed by state law. If your account goes to collections, ALL collection fees will become your responsibility.

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

I have read the Financial Policy. I understand and agree to this Financial Policy.

SIGNATURE:_____ DATE:_____

Bay Dental Center

John C. Collias, DDS

FINANCIAL POLICY

Preferred Method of Payment

- ☐ Credit/ Debit Card
- ☐ HSA Card
- ☐ Care Credit
- ☐ Cash/Check

***Effective immediately- due to the rise in production and interest costs, Bay Dental Center will be adding a 3% convenience fee to all services for credit and debit cards.

_____ _____

Patient Name Date

_____

Patient Signature

Bay Dental Center

Non-Refundable Deposit Agreement

We are excited that you have made a decision to proceed with your dental treatment. However, we need to ask you to agree (by signing below) to our non-refundable deposit requirement for treatment over $200.00. This is necessary because we will be reserving a considerable period of time in order to do your treatment. Taking a deposit and making it non-refundable is the only means we have of assuring protection against a client changing her mind and the practice being left with the losses. Thanks for your understanding.

Our policy is:

1) At the time we schedule your appointment, we will collect a deposit of 50% of your co-pay.

2) The deposit money will be applied to the cost of your treatment.

3) The deposit is non-refundable. If you cancel your appointment, there will be no return of any portion.

4) I recognize that emergencies and events beyond your control may occasionally occur that make it impossible or impractical to keep the appointment. If it does turn out that an emergency or such an event does happen, I will work with you reasonably to reschedule your appointment to the earliest date thereafter that will work for both of us. It will be in my discretion to decide if the reason you provide makes keeping the appointment impractical or impossible. Any further appointments will be governed by this same provision for rescheduling. In no event will the deposit be refundable.

Thank you for your understanding.

_____ Signature

_____ Print Name

_____ Date