ORLANDO FAMILY & COSMETIC DENTISTRY

3191 Maguire Blvd, Suite #251
Orlando, Florida 32803
407-894-1451 phone
407-894-5656 fax

PATIENT INFORMATION

Legal Name of Patient_____ Nickname_____

Address_____ City_____ State____ Zip_____

Cell Phone#_____ Home#_____ Work#_____

Date of Birth____/____/____ Age_____ Social Security#_____-_____-_____ Sex: Male / Female

Driver's License# _____ State____ Email_____

Circle One: Minor Single Married Separated Divorced Widowed Long-Term Partner

Employer_____ Occupation_____

Who referred you to our office _____

PRIMARY DENTAL INSURANCE

Name of Insured_____ Relationship to Patient_____

Insured's address if different than above _____City_____ State____ Zip_____

Cell Phone#_____ Home#_____ Work#_____

Date of Birth____/____/____Social Security#_____-_____-_____ Sex: Male/ Female

Name of Insurance Company_____Group#_____

Address of Insurance Company_____City_____State____Zip_____

Subscriber I.D. # or Member #_____Toll Free Phone # (____) ____-_____

Employer Name_____Occupation_____

SECONDARY DENTAL INSURANCE

Name of Insured_____ Relationship to Patient_____

Insured's address if different than above _____State____ Zip_____

Cell Phone#_____ Home#_____ Work#_____

Date of Birth____/____/____Social Security#_____-_____-_____ Sex: Male / Female

Name of Insurance Company_____Group#_____

Address of Insurance Company_____City_____State____Zip_____

Subscriber I.D. # or Member #_____Toll Free Phone # (____) _____-_____

Employer Name_____Occupation_____

Signature of Patient or Guardian_____**Date**_____

Is Patient a Minor YES / NO If Yes, Print Name of Parent/Guardian_____

MEDICAL HISTORY

Patient Name	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?

_____

_____

Date of Last Dental Visit _____**Last Dental Cleaning** _____**Last Full Mouth X-rays**_____

Previous Dentist's Name _____

Address _____State_____Zip_____

Phone _____

Do you have any dental problems now? ..... Yes No

If yes, please list _____

Is there anything you would change about your smile or oral health? ..... Yes No

If yes, please list _____

Are any of your teeth sensitive to:

Hot or Cold? ..... Yes No

Sweets? ..... Yes No

Biting or Chewing? ..... Yes No

Have you noticed any mouth odors or bad tastes? ..... Yes No

Do your gums bleed or hurt? ..... Yes No

Have you noticed any loose teeth or change in your bite? ..... Yes No

Does food tend to become caught in between your teeth? ..... Yes No

Have you ever had a "deep cleaning" or any type of periodontal treatment? ..... Yes No

Do you smoke or chew tobacco? ..... Yes No

Do you clench or grind your teeth while awake or asleep? ..... Yes No

Do you or have you experienced popping or clicking of the jaw? ..... Yes No

Do you or have you experienced pain in your jaw? ..... Yes No

Are your teeth yellow or heavily stained? ..... Yes No

Are you interested in tooth whitening? ..... Yes No

Are you unhappy with the alignment of your teeth? ..... Yes No

With respect to your past dental experience; Is there anything we should repeat or avoid? Is there anything that happened in another dental office we should be sensitive to? Is there anything else we can do to make you more comfortable? _____

_____

_____

_____

MEDICAL HISTORY

Patient Name	**Medical Alert**

1.) Have you been under the care of a medical doctor during the past two years? ..... Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2.) Are you taking any medication, drugs, or pills now? ..... Yes No

****If yes, please list on the BOTTOM of this form**

3.) Are you aware of having an allergic (**or adverse reaction**) to any medication or substance? ..... Yes No

If yes, please list; _____

_____

_____

4.) Have you been a patient in the hospital during the past five years? ..... Yes No

If yes, please explain; _____

5.) Indicate which of the following you have had, or have at the present. **Circle "Y"es or "N"o to each item**.

Heart (Surgery,Disease,Attack)	Y	N	Ulcers	Y	N	Hepatitis A(Infectious)B(Serum)	Y	N
Chest Pain	Y	N	Diabetes	Y	N	Venereal Disease	Y	N
Congenital Heart Disease	Y	N	Thyroid Problems	Y	N	A.I.D.S.	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	H.I.V. Positive	Y	N
High Blood Pressure	Y	N	Contact Lenses	Y	N	Cold Sores/Fever Blisters	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N	Blood Transfusion	Y	N
Artificial Heart Valve	Y	N	Chronic Cough	Y	N	Hemophilia	Y	N
Heart Pacemaker	Y	N	Tuberculosis	Y	N	Sickle Cell Disease	Y	N
Rheumatic Fever	Y	N	Asthma	Y	N	Bruise Easy	Y	N
Arthritis/Rheumatism	Y	N	Hay Fever	Y	N	Liver Disease	Y	N
Cortisone Medicine	Y	N	Latex Sensitivity	Y	N	Yellow Jaundice	Y	N
Swollen Ankles	Y	N	Allergies or Hives	Y	N	Neurological Disorders	Y	N
Stroke	Y	N	Sinus Trouble	Y	N	Epilepsy or Seizures	Y	N
Diet (special/restricted)	Y	N	Radiation Therapy	Y	N	Fainting or Dizzy Spells	Y	N
Artificial Joints (Hip,Knee,Etc.)	Y	N	Chemotherapy	Y	N	Nervous/Anxious	Y	N
Kidney Trouble	Y	N	Tumors	Y	N	Psychiatric/Psychological Care	Y	N

6.) Do you or have you had any disease, condition, or problem not listed ..... Yes No

If yes, please list: _____

7.) Do you **pre-medicate** with an antibiotic prior to any kind of dental treatment? ..... Yes No

8.) **WOMEN** Are you: **Pregnant**? Yes, ___ Months No **Nursing**? Yes No **Taking birth control pills**? Yes No

LIST OF MEDICATIONS; **	**REVIEW OF MEDICAL HISTORY** (FOR OFFICE USE ONLY) .

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

DENTIST SIGNATURE _____ DATE _____

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Orlando, Florida 32803

FINANCIAL POLICY

We are pleased that you have selected us as your dental care provider. For your knowledge, our Financial Policy is outlined below.

Promise to Pay. Amounts for dental care services provided to you or your family members may be charged to your Account, unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have dental insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with a dental insurance claim as long as the correct insurance information is given before time of service. If there is a change in insurance we ask you provide us with the updated information 24 hours in advance. We do not accept or file Medical Insurance. If you have a secondary insurance you will be expected to pay your portion based on your primary insurance only. As a courtesy we will help you file your secondary insurance claim, but the payment will be made directly to the insured member of the secondary insurance. Insurance is a contract between the policy holder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your Account is your full responsibility. We may also charge to your Account fees set forth below for missed appointments, late payments, returned payments or collection costs. We will provide to you a statement (your "Statement") of your Balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have insurance coverage, we may choose not to send you a Statement until we know or receive the amount reimbursable by your insurance company.

Missed Appointment Fee. We may charge to your Account fees of $50/Hour for a missed appointment or fees for an appointment cancelled without advance notice of at least 48 hours.

Late Payment Fee. If we do not receive payment in full of your Balance within 30 days of the statement date shown on your Statement, you will be assessed a Late Payment Fee of $10.00 for each month your full Balance goes unpaid. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your Balance.

Returned Payment Fee. If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Returned Payment Fee, which is currently $35.00 and may be adjusted due to fluctuating bank charges.

Collection Cost. If we do not receive payment under the terms of this Financial Policy and we refer your Account to a collection agency or an attorney for collection, we may charge to your Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees, to the extent not prohibited by applicable law.

No Waiver by Us. We may waive our right to charge a fee to your Account without waiving any other right we have under this Financial Policy including our right to charge that same fee at any other time.

Communications. By signing this policy you are consenting to allowing our office to communicate with you via phone, text, email, & mail. This communication can include but is not limited to your patient records, receipts and promotional matters such as marketing.

Credit Reports. We, or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other defaults on your account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or may report inaccurate information to a collection agency, please notify us of the specific information that you believe is inaccurate by writing to us at the address above.

As used in this Financial Policy, "we," "us," "our" and "Provider" mean the service provider named above (Orlando Family & Cosmetic Dentistry). "Services" means any services provided by us. "You," "your' and "Account holder" mean the person responsible for paying for services. Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your "Account") as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this Financial Policy.

Yes, I agree to the above terms and conditions.

Account Holder's Signature Print Name Date

ORLANDO FAMILY & COSMETIC DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF OUR PRIVACY PRACTICES (HIPAA) AND OFFICE POLICIES

I, _____, have been presented with the Notice of Privacy Policy (the "Policy") of Orlando Family & Cosmetic Dentistry (the "Provider") and have been offered a copy of such policy to keep for my records.

Please Print Name

Signature

Date

If you would like to permit our office to speak to someone other than yourself, the above named, regarding your treatment please list name(s);