PATIENT DENTAL HISTORY **(Please fill out both sides completely)**

PATIENT NAME_____ Date of Birth: _____

Are you having any dental discomfort or problem at this time? _____

Have you ever had any unpleasant experience in a dental office? _____

Did you ever wear braces or retainer? _____

Name of
Orthodontist: _____

Are any of your teeth sensitive to: Hot?_____ Cold? _____ Pressure _____ Sweets? _____

Are you dissatisfied with the appearance of your teeth? _____ Explained: _____

What was the approximate date of last cleaning?_____ X-rays? _____

How often do you floss your teeth? _____ Type of toothbrush used? _____

Do you used water-jet or other such device? _____

Does food wedge between your teeth? _____ Where? _____

Have you ever had gum treatment or gum surgery?
_____ Explain _____

Do you ever feel that you have bad breath? _____

Do you have bad taste in your mouth? _____

Do you ever notice pain or ringing in your ears? _____

Do you have any sinus problems? _____

Are you aware of any lumps or swelling in your mouth or neck? _____

Do you smoke? _____

Is there anything else you think the Dentist should know or is there anything that you would like to discuss with the Dentist?

_____

_____

_____

_____

_____ _____ _____ -------

Patient Signature Date Dentist Signature Date

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient/Parent of Legal Guardian

LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			DATE
ADDRESS			
CITY		STATE	ZIP
PHONE		FAX	
CELL	EMAIL		
BIRTHDATE	AGE	MALE	FEMALE
SINGLE	SPOUSE/PARTNER	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

Patient Under 18 years old

LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

LAST NAME	FIRST NAME	M.I.
RELATIONSHIP TO PATIENT		SOCIAL SECURITY NO.
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
OCUPATION		
EMPLOYERS NAME		EMPLOYERS PHONE NO.

DENTAL INSURANCE

INSURANCE COMPANY	GROUP NO.
EMPLOYER NAME	INSURED NAME
RELATIONSHIP TO PATIENT	DOB
INSURED'S I.D. NO.	INSURED'S SOCIAL SECURITY NO.

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE		
A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
CLOSEST RELATIVE NOT LEAVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study model, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agreed to use of anesthetics sedatives and other education as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask a complete recital of any possible complications.

4. I agreed to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1- 1 /2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature_____ Date _____ Witness_____

Parent/Responsible Party's Signature_____ Relationship to Patient_____

Orlando Dental Group

Financial Policy

_____ All fees charged by our office are the sole responsibility of the undersigned.
Initial

_____ If you have dental insurance benefits, please remember that insurance is a
Initial **contract between you, your employer, and the insurance carrier**. As a courtesy to our patients, Orlando Dental Group will submit all dental claims to your primary insurance company. Claims not paid by your insurance company within 30 days for any reason, will be billed to your account and **are the responsibility of the patient or guardian**

_____ Insurance benefits are an estimate, not a guarantee of coverage, based on the information
Initial you and your insurance company have provided. Prior to submission of claims, we will inform the patient/Guardian of all procedures, estimated insurance coverage and patient portion before starting treatment. Your estimated patient portion is **due in full at the time you receive treatment.** *Please be advised that treatment is determined by what is deemed medically necessary by your dentist, not by what benefits your insurance company provides.*

_____ Payment options: Cash, Check, Visa, MasterCard, Discover, AMEX, and extended
Initial payment plans through CareCredit* or Chase Health Advantage* (*Must be approved prior to treatment. $500 minimum)

_____ Any outstanding balance beyond 30 days is subject to a 1 ½ % service charge
Initial with a minimum monthly service charge of $1.50. A late fee of $25 will be assessed on any payments received 10 or more days after due date. Returned checks will be charged $25 or 10% of check amount, whichever is greater.

_____ All scheduled treatment requires a 30% deposit of the patient portion to scheduled an
Initial appointment. This deposit will be applied towards treatment.

_____ Orlando Dental Group will charge a broken appointment fee of $40.00 for appointments
Initial cancelled or missed within 2 business days of the appointment time.

_____ The undersigned agrees to pay all reasonable attorneys fees, court costs and collection
Initial fees should collection activity become necessary. If this account is assigned to a collection agency, an additional fee equal to 40% of the outstanding balance will be added to the account.

I have read and understand the Financial Policy of Orlando Dental Group.

_____ _____
Print Name Date

_____
Signature

Orlando Dental Group

Cerec and Insurance

We are proud to offer our Patients the enormous benefits of Cerec Porcelain Restorations. These restorations represent the epitome of modern Dental Technology as they preserve and protect tooth structure. They are also great timesavers to both patients and doctors alike.

Due to the fixed cost of the Cerec machine, the time and materials involve, the fee we charged for these restorations cannot be discounted. Therefore, we offer these Upgrade restorations as options that are **not** subject to the *discounts of dental plans*. If you desire a restoration that does qualify for the Dental Plan discount, we have those available. We will be **happy to file a claim with your dental insurance for the Cerec restoration**, but be aware that most dental plans will pay only according to the least expensive option. To ensure that you are getting the maximum benefit from your insurance we use the ADA code for a <u>standard</u> porcelain restoration.

The patient portion on your treatment proposal is only an <u>ESTIMATE.</u> If you want more specific information on coverage, we suggest that you request a "Pre-Determination of Benefits" *(This is not a guarantee of payment).* Your insurance will usually base its benefit on the most economical treatment. Please consider these points before selecting to upgrade to the option of the Cerec restoration.

REMEMBER: Cerec Restorations <u>Do not</u> qualify for Dental Plan Discounts.

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- You May Refuse to Sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgment of received of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevent us from obtaining acknowledgement

□ Other (Please Specify)

_____

_____

_____