Modern DENTAL CARE

REGISTRATION FORM

Section I: Patient Information

Date: _____

Name: _____ SSN: _____-____-_____ Date of Birth: _____

Address: _____ _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer: _____ Work Phone: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Phone: _____

Section II Responsible Party (if other than you)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Employer: _____ Work Phone (____) _____ SSN#: _____

Section III Insurance Information (if None, skip this section)

Name of Main Insured: _____ DOB: _____

Relationship to Patient: _____

SSN#:_____ Name of Employer: _____ Work Phone: (____) _____

Address of Employer: _____City: _____ State: _____ Zip: _____

Insurance Company: _____ Grp #: _____ ID#: _____

Section IV Dental History

Patient Name: _____

Reason for today's visit: _____

When was your last cleaning:_____

Check if you have any problems with the following:

☐ Bleeding Gums ☐ Grinding Teeth ☐ Sores or growths in your mouth
☐ Clicking or popping of jaw ☐ Loose teeth or broken fillings ☐ Broken Teeth

Is there anything about the appearance of your teeth that you are unhappy with or would like to improve?
☐ Yes ☐ NO If yes, please explain: _____

Section VI Medications

List any medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section VI Allergies (If none, Check None)

☐ Aspirin ☐ Latex ☐ Penicillin
☐ Barbiturates (Sleeping Pills) ☐ Sulfa
☐ Codeine ☐ Metal Allergies
☐ Local Anesthetic
☐ **None**

Other_____
_____
_____
_____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.
Signature: _____ Date: _____

Doctor Signature: _____

Section V **Medical History**

Name: _____ Date:_____

Physician's Name: If none, write None. _____

Date of last Visit: _____

Physician's Phone number _____

Have you had any serious illnesses or operations? _____ If yes, please describe and date_____

_____

Have you had a history of radiation therapy? ☐ Yes ☐ No _____

Have you ever had a blood transfusion? ☐ Yes ☐ No Dates, if applicable: _____

Are you taking any blood thinners? (Aspirin, Plavix, Coumadin) _____

(Women) Are You Pregnant? ☐ Yes ☐ No How long? _____ Taking Birth Control? ☐ Yes ☐ No

Are you taking any bisphosphonates? (Actone, Fosamax) _____

Check if you have any of the following: Check None, if you don't have any of the following or Fill out Other Section.

☐ AIDS	☐ Diabetes	☐ Hepatitis	☐ Pacemaker
☐ Artificial Heart Valve	☐ Epilepsy	☐ Herpes	☐ Rheumatic Fever
☐ Artificial Joints	☐ Fainting	☐ High Blood Pressure	☐ Scarlet Fever
☐ Asthma	☐ Heart Murmur	☐ HIV Positive	☐ Thyroid Problems
☐ Back Problems	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Stroke	☐ Excessive Bleeding	☐ **NONE**

☐ Heart Problems – Describe: _____

Other/Notes:

_____
_____
_____

Patient Signature: _____

Doctor Signature: _____

Office USE ONLY BELOW:

Medical Release Necessary? _____ Physician #: _____

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying to this consent.

Patient Name: _____

Signature: _____

Date: _____

Financial Policy

In consideration for undertaking my care, I agree to the following:

I accept full financial responsibility for the services provided to me by Modern Dental Care of Tampa Bay and I understand that payment is due at the time of service or before. This includes emergency visits for me or any of my dependents, or at the initiation of service under a treatment plan that I or my dependents have requested.

If you have insurance, we will provide an **estimate** of what we think your insurance company will **probably** pay and collect the difference from you. I understand that my insurance company may not cover all necessary balances and may send the check to the wrong party. In the event that the insurance company mistakenly sends a reimbursement check to me for services that were rendered but not previously paid for I will endorse the check to Modern Dental Care of Tampa Bay within 5 business days of said payment.

If the insurance company pays more than we expected, you will have a credit on your account. We will mail you a statement informing you of the credit. You can keep it on your account or we can refund it to you. All outstanding insurance claims must be received before we may issue any refunds.

We will try to arrange payment from your insurance company for a maximum of 60 days. After 60 days, you are responsible for any balance on your account, regardless of whether your insurance company has paid us or not.

I understand that all insurance claims from treatment that I receive from Modern Dental Care of Tampa Bay are being filed by Modern Dental Care with my authorization as a courtesy to me and are subject to review by my insurance carrier. I understand that Modern Dental Care of Tampa Bay will file a claim with my insurance carrier up to two times per appointment and that any further insurance appeal is solely my responsibility. I also acknowledge that I am solely and ultimately responsible for paying all charges not covered by my insurance for any reason, including but not limited to, my insurance denying coverage for any procedure, policy deductibles, policy annual maximum, or lifetime benefits exceeded, my insurance paying an amount for a procedure based on its usual and customary benefit schedule which is less that the fees charged by Modern Dental Care for such a procedure and Modern Dental Care not receiving payment within 60 days of the procedure being performed even if I am appealing the denial of insurance benefits by my carrier.

I understand that If I opt to discontinue treatment for a procedure requested be completed by Modern Dental Care of Tampa Bay, including but not limited to , Partial Dentures, Crowns, Bridgework, Surgical Preparatory work, impressions, I will be responsible for paying all lab costs for materials and services that were provided for my benefit prior to my decision to discontinue such treatment and that all such cost will be deducted from any refund that I may be entitled to as a result of any prepayments for the requested services.

I understand that if a check, or any instrument, or any electronic authorization or debt sent or provided to Modern Dental Care of Tampa Bay for payment is not honored upon first presentment, regardless of the reason, even if the check, instrument, or electronic authorization is later honored, I will be charged a service charge. The charge is currently $25.00 and is subject to change without notice.

Initials (_____) **I understand that the charge for copies of X-rays and treatment information is currently $25.00 and is subject to change without notice.**

When we reserve time for your appointment, we make room in our schedule so we may devote our time and focus our efforts on serving your needs. Late cancellations force us to have empty time in our schedule when we could have been helping another patient. There is a $50.00 charge for every hour reserved for appointments broken or changed without a 48 hour notice.

Patient Name

Signature or Guardian Date: