Summit Park DENTAL

Dr. Walton Van Hoose, DDS
723 CR 466, Lady Lake FL 32159
Phone: (352) 430-0543 Fax: (352) 430-0702

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

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

Home Phone: _____ Work Phone: _____ Employer: _____

Cellular: _____ ☐ Okay to Text appointment reminder.

E-Mail: _____ I would like to receive correspondence via e-mail: Y N

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Marital Status: _____

Emergency Contact: _____ Phone: _____ Relationship:_____

DENTAL HISTORY:

What is the reason of your visit today? _____

Are you experiencing pain or discomfort at this time? ☐Yes ☐No Date started: _____

Are you happy with the appearance of your teeth? ☐Yes ☐

Do you clench or grind your teeth? ☐Yes No

Are you able to eat and chew food satisfactorily? ☐Yes ☐ No

Does your jaw click or pop? ☐Yes ☐ No

Would you like to make your teeth Whiter? ☐Yes ☐ No

Do your gums bleed or feel tender? ☐Yes ☐ No

Do you have headaches, earaches or neck pain? ☐Yes ☐ No

Have you ever had gum treatment? ☐Yes ☐ No

Do you feel your breath offensive at times? ☐Yes ☐ No

Have you lost or removed any teeth? ☐Yes ☐ No

Do your teeth feel loose or separating? ☐Yes ☐ No

Have they been replaced? ☐Yes ☐ No

Does food get caught between your teeth? ☐Yes ☐ No

Fixed Bridge ☐ Date placed: _____

Difficulty opening or closing your mouth? ☐Yes ☐ No

Removable Partial ☐ Date placed: _____

Difficulty in chewing on either side? ☐Yes ☐ No

Full Denture ☐ Date placed: _____

Are your teeth sensitive to Hot or Cold ☐Yes ☐ No

Are your teeth sensitive to sweets ☐Yes ☐ No

Date of last dental visit:	Date of last cleaning:	Last full mouth x-rays:	Do you use dental floss?

How often are your hygiene visits: 3 months ☐ 4 months ☐ 6 months ☐ 1 year ☐

Whom may we thank for referring you to our office? _____

I give my consent to any advisable and necessary dental procedures, medication or anesthetic to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of Insurance coverage. I understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment, and its fee. To the best of my knowledge the information provided on this form is accurate.

All x-rays taken at no charge is the property of Summit Park Dental.
There will be a $55.00 transfer fee to send them to another office or to you.

Signature of Patient: _____ Date: _____

Signature of Doctor: _____ Date: _____

MEDICAL HISTORY

Patient name: _____ Birth Date: _____

Primary Care Physician: _____Physician's Phone:_____

Pharmacy: _____ Location: _____ Telephone: _____

Have you ever had to pre-medicate with antibiotics prior to dental treatment? ☐Yes ☐ No Type: _____

Have you ever been hospitalized or had a major operation? ☐Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐Yes ☐ No If yes, how much?: _____ Do you use controlled substances? ☐Yes ☐ No

WOMEN

Are you Pregnant/trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐ No

Please be advised that antibiotics may reduce the effectiveness of oral contraceptives. Please consult a physician if antibiotics is prescribed. **Signature of acknowledgement**: _____ Date: _____

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal ☐ Erythromycin ☐ Sulfa drugs ☐ Local Anesthetic ☐ Tetracycline ☐ Lidocaine ☐ Latex ☐ Other: If yes, please explain: _____

Please list all your prescription and over-the-counter medication you are taking. Please include herbal or natural supplements.

Are you taking any medication for osteoporosis? ☐ FOSAMAX ☐ _____

Please check all that applies:

___ AIDS/HIV Positive
___ Alzheimer's Disease
___ Anaphylaxis
___ Anemia
___ Angina
___ Arthritis / Gout
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Blood disease
___ Blood Transfusion
___ Breathing Problem
___ Bruise Easily
___ Cancer
___ Chemotherapy
___ Chest Pains
___ Cold Sores / Fever Blisters
___ Congenital Heart Disorder
___ High Cholesterol
___ Convulsions
___ Cortisone Medicine
___ Diabetes
___ Drug Addiction
___ Easily Winded
___ Emphysema
___ Epilepsy or Seizures
___ Excessive Thirst
___ Fainting spells / Dizziness
___ Frequent Cough
___ Frequent Diarrhea
___ Frequent Headaches
___ Genital Herpes
___ Glaucoma
___ Hay Fever
___ Heart Attack / Failure
___Heart Murmur
___ Heart Pace Maker
___ Heart Trouble / Disease
___ Hemophilia
___ Hepatitis A
___ Hepatitis B or C
___ Herpes
___ High Blood Pressure
___ Hives or Rash
___ Hypoglycemia
___ Irregular Heartbeat
___ Kidney Problems
___ Leukemia
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Mitral Valve Prolapse
___ Pain in Jaw Joints
___ Parathyroid Disease
___ Psychiatric Care
___ Radiation Treatment
___ Recent Weight Loss
___ Renal Dialysis
___ Rheumatic Fever
___ Rheumatism
___ Scarlet Fever
___ Shingles
___ Sickle Cell Disease
___ Sinus Trouble
___ Spina Bifida
___ Stomach Intestinal Disease
___ Stroke
___ Swelling of Limbs
___ Thyroid Disease
___ Tonsillitis
___ Tuberculosis
___ Tumors of Growths
___ Ulcers
___ Venereal Disease
___ Yellow Jaundice
___ Osteoporosis
___ Atrial fibrillation

All Payments are expected to pay in Cash, Check or Credit Card the day the service is rendered, unless arrangements are made in advance.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature: _____ Date: _____

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HIPPA: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You may refuse to sign this Acknowledgement"

I, _____, have read and seen a copy of this office's notice of privacy practice.

_____ _____
Signature Date

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because: _____ Individual refuse to sign _____ Communication barriers prohibited obtaining the acknowledgement _____An emergency situation prevented us from obtaining acknowledgement _____ Other (Please specify)

DENTAL INSURANCE INFORMATION ONLY:

Please give your Insurance card and Picture ID to the receptionist to copy for your file.
Whenever possible, we will try to anticipate all cost up front so you may plan your financial obligations. However, sometimes additional material or procedures are necessary during treatment which may result in additional charges.
You are responsible for balances on your account if changes occur. As a courtesy to you, we will submit the claims to your Primary Insurance Company and you will be responsible for any additional secondary Insurance Claims.
We DO NOT GUARANTEE Insurance benefits OR payments.
The Insurance is an estimate of payment expected and not a guarantee of payment and Summit Park Dental is not responsible for any amounts not paid by your Insurance and it is the patients' responsibility to follow up on their Insurance.
Patient acknowledge, he/she is fully responsible for the total charges provided by Summit Park Dental.

Patient signature: _____ Date: _____

Name of Insured: _____ Relationship to Insured: __ Self __ Spouse

Insures SSN: _____ Insured Birth Date: _____

Employer: _____ Retired from: _____

Insurance Company: _____ Group Number: _____

Insurance Address: _____ City: _____ State: ___ Zip: _____

Insurance Telephone Number: _____

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SUMMIT PARK DENTAL, INC

Financial Agreement

Professional services are rendered and charged to you, not the insurance company. Please understand that the contract is between you and the insurance company and payment for services is your responsibility. In order to honor any insurance benefits, you must provide insurance identification.

All deductibles and fee amounts not covered by insurance are due at the time of treatment. The office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. We will file your claim once. You will receive a statement of your account balance shows an amount due, regardless of insurance expectations. If at the end of 60 days, your insurance company has not paid, you are responsible for the entire balance. Upon request, we will supply you with a copy of the claim, so you can resubmit. **Initial** _____

Office Fees:

If you present a check for insufficient funds, or place a stop payment on an issued check, you will be charged a $50 fee for processing and your checks will no longer be honored here.
PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED. WE ACCEPT CASH, CHECK, CREDIT CARDS AND MOST INSURANCE PLANS. Initial _____

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that patients make every effort not to change reserved dental appointments.
Broken and missed appointments create scheduling problems for other patients as well as the practice. If you find that you must change your appointment, we require a minimum 24 hour notice, so that we may accommodate another patient. A charge in the amount of $50.00 will be applied for broken/ missed appointments without 24 hours advance notice.
Thank you for your cooperation in this matter. **Initial** _____

We will charge 1.5% monthly (18% annual) interest on account balances over 60 days. If your account balance is not cleared after 90 days, your account will be turned over to a collection agency and will be subject to additional fines/charges. **Initial** _____

I HAVE READ AND UNDERSTAND THE STATEMENT LISTED ABOVE.

SIGNED: _____ DATE: _____

PRINTED NAME: _____

Thank you for choosing our practice. We appreciate the trust you have placed in us.