PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-051576/27000

X _____ PATIENT NUMBER _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT'S NAME _____ DATE OF BIRTH _____

Reason for this visit _____

When was your last dental visit _____ What was done then _____

How often did you visit the dentist before then _____

Previous dentist (name and location) _____

Have you had a complete series of dental films (x-rays) taken When Where _____

How often do you brush your teeth _____ How often do you floss your teeth _____

Is your drinking water fluoridated _____

How do you feel about losing your teeth _____

Do you wear dentures? ☐ Yes ☐ No If yes, how old _____

MEDICAL HISTORY

Physician's Name _____ Phone _____ Last physical exam: _____

Address _____

(Women) Are you pregnant? ☐ Yes ☐ No How long? _____

Are you under a doctor's care now? ☐ Yes ☐ No If so, for what reason? _____

Are you taking any medications, pills, drugs, or oral contraception? ☐ Yes ☐ No Please list: _____

Do you smoke: ☐ Yes ☐ No Do you consume more than 3 oz. of alcohol daily? ☐ Yes ☐ No

Have you ever had any of the following?

Unusual weight gain or loss? ☐ Yes ☐ No

	Yes	No
Heart Trouble	☐	☐
Arthritis	☐	☐
Hepatitis	☐	☐
Heart Murmur	☐	☐
Rheumatic Fever	☐	☐
Chest Pain	☐	☐
Heart Surgery	☐	☐
Chemotherapy (Cancer)	☐	☐

	Yes	No
Asthma	☐	☐
Artificial Joints	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐
Kidney/Liver Problems	☐	☐
Fainting Spells	☐	☐
High Blood Pressure	☐	☐

	Yes	No
Psychiatric Treatment	☐	☐
Prolonged Bleeding	☐	☐
Herpes	☐	☐
H.I.V. (Aids)	☐	☐
Venereal Disease	☐	☐
Radiation Disease	☐	☐
Thyroid	☐	☐
Sickle Cell (Trait/Disease)	☐	☐
Blood Transfusions	☐	☐

Have you had any serious illness? ☐ Yes ☐ No Explain: _____

Have you been to the hospital in the last two years? ☐ Yes ☐ No Why? _____

Drug Allergies: Pencillin ☐ Sulfa ☐ Codeine ☐ Aspirin ☐ Epinephrine ☐ None ☐ Other _____

Do you have any other Dental or Medical problems not listed? ☐ Yes ☐ No

DATE: _____ SIGNATURE: _____
Patient/Parent or Guardian

Reviewed by: Doctor _____ Date: Blood Pressure: _____

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	SIGNATURE	B.P.

FORM 063157 R/06/01 ITEM 8101

PATIENT MEDICAL/DENTAL HISTORY

CAPESIDE DENTAL
3265 Bayside Lakes Blvd.
Palm Bay, FL 32909

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Capeside Dental PA to use and disclose my protected health information to carry out:

*** Treatment (including direct or indirect treatment by other healthcare providers)**
*** Obtaining payment from third party payers- insurance companies, etc.**
*** The day to day healthcare operations of your practice**

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practice*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of _____, 20___.

Print Patient Name_____

Relationship to Patient_____

Signature:_____

Cape Side Family Dentistry

Written Financial Policy

Thank you for choosing Cape Side Dental, Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa or MasterCard

  We offer 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans over $1000 or more.

- NO INTEREST Payment Plans from CareCredit
  - Allows you to pay over time with NO INTEREST to CareCredit
  - Convenient, low monthly payment plans
  - No annual fees or –pre-payment penalties

Please note:

Cape Side Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans of $250 or more, a 10% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. If for any reason your insurance does not pay within 30 days, the balance will become your responsibility.

A $25 fee may apply for appointments missed or cancelled with less than 24 hours notice.

Cape Side Dental charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)