

NEW PATIENT INFORMATION PACKAGE

WELCOME!! In order to take us excellent care of you as possible, please answer all of the following questions:

Patient's Name: _____

Check one: single married divorced seperated widowed

Patient's Birth Date: _____ Patient's Social Security Number (SSN#): _____

Telephone: home _____ work _____ cell _____ e-mail _____

Name of spouse or parent: _____ Spouse's SSN#: _____

Home Address: _____

city _____ state _____ zip _____ country _____

Patient's Employer: _____ Spouse's Employer: _____

Whom may we thank for referring you? _____

Are you being treated by a physician? Y / N Name: _____

Are you taking any medications? Y / N If so, please list: _____

Do you have, or have you had, any of the following? Please check all that apply:

Heart trouble Rheumatic fever Seizures Diabetes
 Hepatitis Prolonged bleeding Tuberculosis Aids
 HIV Positive High Blood Pressure Women, are you pregnant? Y / N Month: _____

Have you ever had radiation treatments? Y / N Do you need premedication before dental appointments? Y / N

Have you had any artificial valves or joints? Y / N

Do you have any allergies? Y / N If so, please list: _____

Is there anything else about your health that we should now about? _____

Reason for visit: _____

Would you like the doctor to fully evaluate your oral health? Y / N If so, an estimate will be given.

Would you like to be called for regular professional dental cleanings and examinations? Y / N

Name of person responsible for charges: _____ Do you have dental insurance? Y / N

Name of Insurance Co: _____ Group Number: _____ Employer: _____

Payment of professional fees:

- The balance of this account is due before the next monthly statement unless prior arrangements have been made for extended payments. A service charge of 1-1/2% per month will be added to the balance.
- If professional services are required to recover unpaid balances, patient agrees to be responsible for any and all associated fees, including legal fees and collection charges.

Signature: _____ Today's date: _____

Driver's License Number: _____ May we contact you via e-mail? Y / N



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5975 SUNSET DRIVE; SUITE 502
SOUTH MIAMI, FLORIDA 33143

FINANCIAL AGREEMENT

1. Payment is due at time of service

Our office is a fee for service practice, dedicated to providing the best possible dental care to each and every one of our patients.

For your convenience, we accept the following forms of payment:

- *Cash*
- *Check*
- *Major credit cards*
- *In-office financing plans (ask for details)*

2. Insurance

We have always found that dental insurance is helpful to our patients that are fortunate enough to be covered. However, insurance coverage is not intended to either pay for 100% of services, or absolve the insured of their responsibility to pay.

As a courtesy to our family of patients, we will file insurance claims on their behalf. Please note, however, that insurance claims that are more than sixty (60) days outstanding will become the patient's responsibility. If the insurance company pays after that date, we will gladly refund that payment to our patient.

Your co-payment is due at the time services are rendered, please do not ask us to waive it or delay it.

3. Account Management

After (90) ninety days without payment or other arrangements, accounts will be considered seriously delinquent. At this point, accounts will be turned over to our attorney David E. Newman for collections. We are understanding of individual circumstances and situations, but a lack of communications and failure to inform us will result in this unfortunate action.

4. We are here to help

If at any time you have questions about your account or your treatment plan, feel free to ask. That is what we are here for! Your dental health is our primary concern, and our job is to provide the best treatment for you in a way that fits your budget.

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THE UNDERSIGNED agrees, whether he or she signs as parent, spouse, guarantor, guardian, or patient, that in consideration of the services to be rendered to the patient, he or she individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees & collection expenses.

Print Patient's Name

Date: _____

Patient's Signature

Date: _____

Parent/Spouse/Guardian Signature

Social Security Number

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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 acknowledgement of receipt 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 prevented us from obtaining acknowledgement
- Other (Please Specify)

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(This form is educational only, does not constitute legal advice, and covers only Federal, not State, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision.)

INSURANCE VERIFICATION FORM

Subscriber's Name: _____

Subscriber's ID#: _____ Subscriber's Date of Birth: _____

Patient's Name: _____

Patient's Relationship to subscriber: _____ Patient's DOB: _____

Phone: _____ Appointment Date: _____

Insurance Company: _____ Phone: _____

Address: _____

Group Name: _____ Group Number: _____ Payer ID#: _____

BENEFITS

Effective Date: _____ Calender Year Policy? _____

Waiting Periods? _____ Annual Max: _____ Max Used to Date: _____

PREVENTATIVE: _____

Exam & Prophy: _____ Eligible?: _____

Bite Wings: _____ Eligible?: _____

FMX or Pano: _____ Eligible?: _____

Sealants: _____ Up to the age of: _____

Fluoride: _____ Up to the age of: _____

Notes: _____

BASIC: _____

Perio: _____ Endo: _____ Oral Surgery: _____ Denture Repairs: _____ Basic Restorative: _____

Frequency Limits for Perio Scaling and Root Planing: _____

Perio Maintenance: _____

Notes: _____

MAJOR: _____

Crowns and Bridges: _____ Frequency Limit: _____ Missing Tooth Clause? _____

Dentures and Partials: _____ Frequency Limit: _____ Implants: _____

Notes: _____