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**ADULT PATIENT INFORMATION**

Patient’s name

 Last First Middle

Residence

 Street City Zip

Mailing Address

 Street City Zip

Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: Single\_\_ Married\_\_ Widowed\_\_ Separated\_\_ Divorced\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No. years employed

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No. years employed

Social Security # Birthdate Work Phone

Whom may we thank for referring you to our office?

**EMERGENCY INFORMATION**

Name of nearest relative not living with you

Complete address

 Street City Zip

Phone

**RESPONSIBLE FINANCIAL PARTY**

**I understand that I am financially responsible for all charges.**

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Relationship to Patient:

I understand that, where appropriate, credit bureau reports may be obtained.

Signature

Updates (date & initial)

**CONSENT FOR TREATMENT**

**I consent to diagnostic procedures and treatment performed by the dentist.**

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

I understand that, where appropriate, credit bureau reports may be obtained.

Signature

MEDICAL HISTORY

Physician Date of Last Visit

Address Phone

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?

Yes No Are you allergic to any medication?

Yes No Do you have a history of a major illness?

Yes No Have you had any operations?

Yes No Have you ever been involved in a serious accident?

Yes No Have you ever smoked or chewed tobacco?

Yes No Have you seen a physician in the last 12 months? Why?

Yes No Do you require pre-med antibiotics before a dental procedure?

Yes No Do you have artificial pins or joints?

Yes No Do you have any heart conditions? Please list

Yes No Heart Attack/Stroke? Year

Yes No Cancer/Tumor? Year

Yes No Have you ever received radiation or chemotherapy? Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Female Patients only:**

Yes No Are you pregnant?

Yes No Do you take birth control?

Yes No Are you on hormone replacement therapy?

**Circle any of the medical conditions below that you have had or currently have.**

Abnormal bleeding Drug Abuse High Blood Pressure Sinus Problems

Alcohol Abuse Emphysema High Cholesterol Thyriod Problems

Angina Pectoris/Chest pain Epilepsy HIV/AIDS Tuberculosis

Arthritis Fainting/Dizziness Mitral Valve Prolapse

Artificial Heart Valve Frequent Headaches Osteoporosis

Asthma Heart Murmur Prolonged Bleeding

Diabetes Type I or II Hepatitis/Liver problems Rheumatic Fever

Dizziness Herpes Sexually Transmitted Disease

Are there any medical conditions we have not discussed that you feel we should be aware of?

**ALLERGIES**

Acetaminophen (Tylenol) Yes No Ibuprofen (Advil, Motrin) Yes No

Aspirin Yes No Fluoride Yes No

Barbiturates, Sedatives Yes No Latex/Rubber Yes No

Codeine Yes No Penicillin/Other Antibiotics Yes No

Dental Anesthetics (Novacaine) Yes No Sulfa Drugs Yes No

Erythromycin Yes No Tetracycline Yes No

Are there any other allergies to medications not listed?

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# DENTAL HISTORY

What concerns you most about your teeth?

# Yes No What type of implant treatment are you interested in?

# Single tooth Full replacement Upper Lower Both

Yes No Are you presently in any dental pain?

Yes No Are you aware that some appointments will be during work hours?

What are the most important factors/questions that you want clarity on prior to moving forward with treatment?

Signature: Date:

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**Financial Arrangements and Dental Insurance Estimation of Benefits**

We are committed to providing you with the best possible care. If you have Dental Insurance we are able to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Undergoing a Surgical/Implant procedure is an investment in yourself – in how you look and how you feel. Most cosmetic procedures and preventative/wellness programs are elective treatments and are not covered by traditional insurance plans. Here at Dental

Implants of Ocala, we understand budgets and we know that yours may not allow you the freedom to pay up-front for the care you need and deserve. So we are proud to offer you financing through Care Credit, Lending Club, HCS and Proceed. We accept cash, checks, American Express, Discover, MasterCard, Visa, Flex spending accounts and HSA’s. While many dental procedures qualify for insurance coverage, there are many others that do not. For example, insurance never covers cosmetic treatments, and many other very beneficial restorative procedures, such as dental implants, usually qualify for little, if any, coverage. Meanwhile, some insurance plans cover preventative dentistry only, meaning patients themselves must pay for anything other than regular checkups and routine cleanings. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that: Your insurance is a contract between you, your employer, and your insurance company. \*\*WE ARE NOT A PARTY TO THAT CONTRACT\*\* Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay for this region. Thus, our fees are considered usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on the arbitrary “schedule” of fees, which bears no relationship to the current standard and cost of care in this area. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover. If you have any questions about the above information or any uncertainty regarding insurance coverage PLEASE do not hesitate to ask us. We are here to help you.

**CANCELLATION POLICY**

**We require 72 hours cancellation notice for all surgeries.**

I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information in this document and completed the appropriate answers.

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the supplied information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature or Parent/Guardian Signature (if minor) Date

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**Acknowledgment of Receipt of Notice of Privacy HIPPA Compliance**

**Dental Implants of Ocala, PA**

“You may refuse to sign this acknowledgment.”

**I have received a copy of this office’s Notice of Privacy Practices.**

**Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_**

**VIDEO AND PHOTO RELEASE FORM**

I hereby grant Dental Implants of Ocala permission to use my likeness in a photograph, video, or other digital media (“photo”) in any and all of its publications, Including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Dental Implants of Ocala and will not be returned.

I hereby irrevocably authorize Dental Implants of Ocala to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears.

Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge the Dental Implants of Ocala from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf of my estate have or may have by reason of this authorization.

**I HAVE READ AND UNDERSTAND THE ABOVE PHOTO/VIDEO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE,**

**OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GAURDIANS AS EVIDENCED**

**BY THEIR SIGNATURES BELOW. I ACCEPT:**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

**If under 18, both parents must sign individually and as parent/guardian.**

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_