Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form. We look forward to working with you in maintaining your dental health.

Referring Dentist: Dr._____

Patient Information (Please Print)

Date_____

Name_____ Soc. Sec.#_____
Last First middle initial

Address_____

City_____ State_____ Zip Code_____

Home Phone # (___)_____ Can we leave confidential information at this number? Yes_____ No_____

Work Phone # (___)_____ Ext._____ Can we leave messages at this number or in your voicemail? Yes_____ No_____

Cell Phone #__(___)_____ Can we leave confidential messages at this number? Yes_____ No_____

E-mail address_____ Can we leave confidential messages at your email? Yes_____ NO_____

Additional Contact_____ Phone # (___)_____ Ext._____ Relationship to you_____
Last name First name

Can we leave confidential messages with above person? Yes_____ No_____

Sex M____ F____ Age_____ Birthdate mth._____ day_____ year_____ Marital status_____

Employer_____ Occupation_____

Employer's address_____ Employer's phone #_____

Spouse's name_____ Birthdate_____ Soc. Sec. #_____

INSURANCE INFORMANTION:

Name of insured: _____ Birthdate:_____ SS #_____
Mth: day year insured

Insured's address: (If different from patient)_____

Insurance Company_____ Group # _____

DENTAL HISTORY :

PLESE CHECK THEM ALL:YES OR NO TO INDICATE IF YOU HAD ANY OF THE FOLLOWING:

Bad breath	Yes_____No____	Grinding teeth	Yes_____No_____
Burning sensation on tongue	Yes_____No____	Gums swollen or tender	Yes_____No_____
Cigarette, pipe or Cigar smoking	Yes_____No____	Jaw pain or tiredness	Yes_____No_____
Dry mouth	Yes_____No____	Periodontal treatment	Yes_____No_____
Food collection between teeth	Yes_____No____	Sensitivity to cold	Yes_____No_____
Bleeding gums	Yes_____No____	Sensitivity to sweets	Yes_____No_____
		Sensitivity when biting	Yes_____No_____
		Clicking or popping jaw	Yes_____No_____

OVER

MEDICAL HISTORY

Phone# ( )_____

Physician's Name:DR:_____ **Fax #** ( )_____ Date of last visit_____

Please check Yes or No to indicate if you have had any of the following: PLEASE CHECK THEM ALL YES OR NO

Aids	Yes____ No____	Epilepsy	Yes____No____	Psychiatric care	Yes____No____
Anemia	Yes____ No____	Fainting or dizziness	Yes____No____	Radiation treatment	Yes____No____
Arthritis, Rheumatism	Yes____ No____	Glaucoma	Yes____ No____	Respiratory Diseas	Yes____No____
Artificial Heart Valves	Yes____ No____	Heart Murmur	Yes____No____	Rheumatic fever	Yes____No____
Artificial Joints	Yes____ No____	Heart Problems	Yes____No____	Scarlet Fever	Yes____No____
Asthma	Yes____ No____	Hepatitis type_____	Yes____No____	Shortness of breath	Yes____No____
Back problems	Yes____ No____	Herpes	Yes____No____	Sinus trouble	Yes____No____
Bleeding abnormally with Extractions or surgery	Yes____ No____	High Blood pressure	Yes____No____	Skin rash	Yes____No____
Blood Disease	Yes____ No____	HIV positive	Yes____No____	Stroke	Yes____No____
Cancer	Yes____ No____	Jaundice	Yes____No____	Swelling feet or ankles	Yes____No____
Chemical dependency	Yes____ No____	Jaw pain	Yes____No____	Swollen neck glands	Yes____No____
Chemotherapy	Yes____ No____	Kidney disease	Yes____No____	Thyroid problems	Yes____No____
Circulatory problems	Yes____ No____	Liver disease	Yes____No____	Tonsillitis	Yes____No____
Congenital heart lesions	Yes____ No____	Low blood pressure	Yes____No____	Tuberculosis	Yes____No____
Cortisone treatments	Yes____ No____	Mitral valve prolapsed	Yes____No____	Tumor or growth on Head or neck	Yes____No____
Diabetes	Yes____ No____	Nervous problems	Yes____No____	Ulcer	Yes____No____
Emphysema	Yes____ No____	Pacemaker	Yes____No____	Venereal Disease	Yes____No____

Women:

Are you pregnant Yes____ No____

Are you nursing? Yes____No____

Other_____

MEDICATIONS

List medications you are currently taking, **INCLUDING ASPIRIN?**

_____

_____

_____

Pharmacy Name_____

Pharmacy Phone #_____

ALERGIES

Aspirin_____ Local Anesthetic_____

Barbiturates (sleeping pills)_____ Penicillin_____

Codeine_____ Sulfa_____

Iodine_____ Other_____

Latex_____

OFFICE POLICY-PLEASE READ BEFORE SIGNING

APPOINTMENTS

We strive to give you excellent care. The time for your appointment has is reserved just for you. **OUR OFFICE WILL GIVE YOU A COURTESY CALL. BUT IF UNABLE TO KEEP AN APPOINTMENT, KINDLY GIVE OUR OFFICE A 72-HOUR NOTICE. FAILURE TO DO SO, WILL INCUR A BROKEN FEE APPOINTMENT**. Fees will be validated 90 days from consultation. Payment is due at the time services are rendered. Three broken appointments without a 72-hour notice will result in dismissal from our office.

INSURANCE

Insurance companies do not guarantee payment on either written or verbal verification. Insurance coverage is a contract between patient/employer and the insurance company. It's your responsibility to be aware of your insurance coverage and limits. If your carrier has not made payment after your claim has been filed for 30 days, you will be billed due balance. Should your account become delinquent it will be forward to a collection agency at your responsibility for any cost of collection incurred.

There are fees for the following services not covered by insurance companies and are the responsibility of the patient/guarantor: Record photocopying, x-rays duplicating, completion of forms, reports and returned checks. Original X-rays will be retained at our office. There is a fee of $ 15.00 for x-rays duplication.

I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I authorize the doctor to release any information necessary to secure the payment of benefits. I understand I'm financially responsible whether or not paid by insurance. I authorize this signature on all insurance. I have read, answered to the best of my knowledge and agreed to all of all information on this welcome form.

Signature_____ **Date**_____

ENDODONTICS & PERIODONTICS ASSOC., PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A:
PATIENT GIVING CONSENT

NAME (Patient)_____Date of Birth: Month._____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, a physician providing treatment to you, healthcare operations in case of a incapacity or emergency situation, if we believe you are a victim of Domestic violence or the possible victims of other crimes, to the proper authorities.

Family member or Friends: We may use or disclose your health information to a family member or another person that you agree we may do so: Yes___No___ if Yes,

Full Name:_____Relationship to you_____.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

ENDODONTICS & PERIODONTICS ASSOC., PA., CROWN POINTE PROFESSIONAL CENTER

4244 W. LINEBAUGH AVE. TAMPA, Fl 33624-Telephone # (813) 960-9080

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

(Signature) I_____Date:_____,

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

TO BE FILLED ONLY IF YOU ARE A REPRESENTATIVE IN BEHALF OF A PATIENT

Personal Representative's Name (PRINT)_____Date of Birth:_____

Patient's name_____Birthdate_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

Signature_____Date_____

FILL ONLY IF YOU ARE REVOKING CONSENT: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature:_____Date:_____ >>>>>>>OVER>>>