PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: ______________________ FIRST: ____________________ INITIAL: __________

How do you wish to be addressed? ______________________ DOB __________

(❑ Single ❑ Married ❑ Divorced) (❑ Male ❑ Female) Full time Student? ❑ Yes ❑ No School __________

Address ______________________

City ______________ State ______________ Zip ______________

Telephone (Home) ______________ (Work) ______________ (Mobile) ______________

Email ______________________

Employer ______________________ Occupation ______________

Soc. Sec. No. ______________ Dental Insurance Co. ______________ Group __________

Is patient covered by another dental insurance? ❑ Yes ❑ No Insurance Co. ______________

How did you hear about our practice? Whom may we thank for your referral? ______________

How important is your oral health to you? __________ How much do you like your smile? __________

In a scale 1-10, (1-4 Not Important - 5-7 Somehow Important - 8-10 Very Important)

What would you change about you smile? ______________________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Last Name ______________ First ______________ Initial __________

Address ______________________ DOB __________

City ______________ State ______________ Zip ______________

Telephone (Home) ______________ (Work) ______________ (Mobile) ______________

Email ______________________

Employer ______________________ Occupation ______________

Soc. Sec. No. ______________ Dental Insurance Co. ______________ Group __________

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

Signature ______________________ Date ______________

PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION – THANK YOU!

PATIENT LAST NAME: ____________________________ **PATIENT FIRST NAME:** ____________________________

DENTAL HISTORY

Reason for today's visit: ______________________________________ Date of last dental visit: ______________________________________

Former dentist: ______________________________________ Date of last dental x-rays: ______________________________________

Please check if you have/had:

- Bad breath ☐
- Blisters on lips or mouth ☐
- Burning sensation on tongue ☐
- Chew on one side of mouth ☐
- Cigarette, pipe, or cigar smoking ☐
- Smokeless tobacco ☐
- Dry mouth ☐
- Food collection between teeth ☐
- Clench teeth ☐
- Grind teeth ☐
- Growths or sore spots in mouth ☐
- Gums swollen, tender, or bleeding ☐
- Head, neck, or jaw pain or aches ☐
- Lip or cheek biting ☐
- Loose teeth or broken fillings ☐
- Mouth breathing ☐
- Orthodontic treatment ☐
- Nitrous Oxide ☐
- Periodontal treatment ☐
- Sensitivity to pressure or irritants (cold, heat, sweets) ☐
- How often do you floss? ______________
- How often do you brush? ____________

Have you ever had an allergic reactions to Novocaine, local or general anesthetics? ☐

If Yes, please explain:

____

Have you had trouble from previous dental care? ☐

If Yes, please explain what happened:

____

____

MEDICAL HISTORY

Physician's name: ____ Date of last visit: ____________

Physician's address: ____

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: ____

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: ____

Pregnant? Yes ☐ Due Date? ______________________ Nursing? Yes ☐ Birth Control Pills? Yes ☐

Please check if you have/had:

- Allergies, hay fever, sinusitis ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Asthma: Required Hospitalization ☐
- Asthma: Used Steroids ☐
- Bleeding abnormally with operation/surgery ☐
- Blood Disease, Clotting Disorders ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Circulatory Problems ☐
- Cortisone Treatments ☐
- Cough, persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis? ☐
- Type: ______________________________
- Herpes ☐
- High Blood Pressure ☐
- Any Immune Deficiency (incl. HIV/AIDS) ☐
- Jaundice ☐
- Kidney Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapsed ☐
- Osteopenia ☐
- Osteoporosis ☐
- Pacemaker ☐
- Radiation Treatments ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Sickle Cell Anemia ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or Growth on Head/Neck ☐
- Ulcer ☐
- Venereal Disease ☐
- Weight Loss, Unexplained ☐
- Do you wear contact lenses? ☐
- Do you consume alcoholic beverages? ☐
- Are you currently under the care of a Physician? ☐
- Are you allergic/sensitive to Latex? ☐
- Allergic to penicillin, Aspirin or Other Drugs? ☐

If Yes, please specify:

____

____

Are you currently taking any Medications? ☐

If Yes, please list:

____

____

____

____

____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: ____ Date: ______________

Reviewed by: ____ Date: ______________

PATIENT NAME:____ **DATE:** ____________________

Miami Lakes Dental Ass, is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- ***Miami Lakes Dental Ass PROVIDES*** **INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

INSURANCE

Miami Lakes Dental Assc provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Miami Lakes Dental staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to Miami Lakes Dental Ass. However, if you are paid by the insurance company instead of Miami Lakes Dental Ass, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

MEDICARE/ MEDICAID/ WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the ***Miami Lakes*** Dental Ass office on the date of service.

DELINQUENT PAYMENTS

Office policy after 30 days of outstanding balance the account will be handling by the collection department.

BROKEN APPOINTMENTS

Unless cancelled at least 24 hours in advance, our office policy is to charge for BROKEN appointments $35.00. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature ______________________________ **Date** ____________________

F I N A N C I A L P O L I C Y