

Patient Information Form *(Please Print)*

Today's Date _____

First Name _____ **MI** _____ **Last Name** _____

Social Security # _____ **Driver's License Number** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone() _____ **Work**() _____

Cell() _____ **E-mail (optional)** _____

Date of Birth _____ **Sex:** M F **Married** **Single** **Divorced** **Other**

Student? Yes No **School Name** _____

Employer Name _____

Address, City, State, Zip _____

Person Responsible for this account _____

Relationship to Patient _____

Emergency Contact _____ **Relationship** _____

Address, City, Zip _____ **Phone** _____

Primary Insurance Subscriber

First Name _____ **MI** _____ **Last Name** _____

Social Security Number _____ **Date of Birth** _____ **Sex:** M F

Address, City, State, Zip _____

Home Phone _____ **Work Phone** _____

Relationship to Patient: Self Spouse Child Other _____

Employer Providing Insurance

Employer Name _____

Address, City, State, Zip _____

Insurance Information

Primary Dental Insurance Company Name _____

Address _____ **Phone** _____

Policy Number _____ **Group Number** _____

Secondary Dental Insurance Company Name _____

Address _____ **Phone** _____

Policy Number _____ **Group Number** _____

Primary Care Physician _____

Address _____ **Phone** _____

Pharmacy Name _____ **Phone** _____

Referred by: _____

Patient Medical History (Please check Yes or No)

Are you under medical treatment now? Yes No

Have you been hospitalized for any surgical operation or serious illness within the last 5 yrs? Yes No

If Yes, please explain _____

Are you taking any medication(s) including non-prescription? Yes No

If Yes, please list: _____

Have you been advised to take an antibiotic before any dental procedure?

Yes No If yes, please explain: _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Are you wearing contact lens? Yes No

For Women: Are you pregnant or think you are pregnant? Yes No

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

Are you allergic to any of the following:

Y N Local anesthetics (e.g. Novocain)

Y N Iodine

Y N Penicillin or other antibiotics

Y N Aspirin

Y N Codeine

Y N Any metals (e.g. nickel, mercury, etc.)

Y N Sulfa

Y N Latex Rubber

Y N Barbiturates

Other (please specify) _____

Y N Sedatives

Do you have or have you had any of the following:

Y N High Blood Pressure

Y N Heart Murmur

Y N Chest Pains

Y N Heart Attack

Y N Mitral Valve Prolapse

Y N Stroke

Y N Rheumatic Fever

Y N Angina

Y N Hay Fever/Allergies

Y N Fainting

Y N Anemia

Y N Tuberculosis

Y N Asthma

Y N Emphysema

Y N Radiation Therapy

Y N Low Blood Pressure

Y N Cancer

Y N Glaucoma

Y N Epilepsy/Seizures

Y N Joint Replacement or Implant

Y N Recent Weight Loss

Y N Leukemia

Y N Hepatitis/Jaundice

Y N Diabetes

Y N Sexually Transmitted Disease

Y N Liver Disease

Y N AIDS or HIV infection

Y N Stomach Troubles/Ulcers

Y N Respiratory Problem

Y N Thyroid Problem

Y N Cardiac Pacemaker

Other _____

Do any of the following apply:

Y N Bleeding Gums (while flossing or brushing)

Y N Sensitivity to Hot or Cold food or liquids

Y N Sensitivity to Sweet or Sour food or liquids

Y N Sores or lumps in or near mouth

Y N Head, neck or jaw injuries

Y N Difficult extractions in the past

Y N Prolonged bleeding following an extraction

Y N Wear dentures or partials

Y N Orthodontic treatments (past or present)

Y N Frequently biting lips or cheeks

Problems in your jaw

Y N Clicking

Y N Pain (joint, ear, side of face)

Y N Difficulty in opening or closing

Y N Difficulty in chewing

Y N Frequent headaches

Y N Clenching or grinding your teeth

Authorization and Release

I certify that I have read and answered the questions on the Patient Information Form accurately and understand the information given. I understand that providing incorrect information can be dangerous to my health. I hereby authorize and request the performance of dental services for my child or myself. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or supervised staff for diagnostic purposes or dental treatment.

I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that I am financially responsible for non-covered services, all deductibles my co-payment amount and any other amount that is not payable under my insurance policy.

I understand that in the event I default in my payment for said services I can be charged an amount to cover collection or attorney fees.

Date _____ Signature _____

Parent/Guardian Signature & Relationship _____

FINANCIAL POLICY

Our experience has shown us that many questions and/or problems about our financial policies can be avoided by understanding our office policies.

Our office policy requires that payment is due in full at the time your dental treatment is rendered. We accept cash, check (with proper ID), Visa, MasterCard and American Express.

As a courtesy to our patients with dental insurance, our doctors may agree to accept a patient's insurance assignment. If our front desk staff is able to determine the expected coverage of your insurance plan, our office will submit your claim to your insurance company. We will wait up to 60 days for the insurance payment to be received and applied to your account. The responsible party for the account must pay any deductible, co-payments, or difference between the insurance company fees and the office fees at the time services are completed.

If for any reason your insurance company does not pay the insurance claim or does not pay the full amount of the expected benefit within 60 (sixty) days from the date of service, the balance will be transferred from an insurance balance to a personal balance, including a service charge of 1.5%. A statement will be sent to the responsible party and payment will be expected within 10(ten) days. Any unpaid balance will be subject to 1.5% interest per month. There will be a \$25 service charge on all returned checks. If your account is turned over to a collection agency, you are responsible for any cost incurred in collection of said balance(s), which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

An important issue to remember is that the doctor will prescribe dental treatment on the basis of their patient's need not on the dental treatment the insurance will or will not cover.

There are two issues with our financial policy that you must consider:

First, it is our financial policy that the balance due on your account is YOUR responsibility, not the insurance company's, and is YOUR balance. It is your responsibility and your benefits provider at work to know your insurance policy. It is YOUR responsibility to be aware of any deductibles, yearly maximums, co-payments or non-covered services. It is also YOUR responsibility to notify the office staff if there are any changes in your insurance coverage.

Second, the insurance coverage quoted to you is just an **ESTIMATE** of the services you will receive. Payment by your insurance company is not guaranteed from the pre treatment estimate.

The doctor and staff are committed to work with our patients to help them secure the maximum dental benefits to which they are entitled. If you have any questions concerning this information, please do not hesitate to contact our office to assist you.

Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Curtis R. Moore, D.M.D.
Charles W. Moore, D.M.D.**

Hilary R. Dalton, D.M.D., M.S.

**6025 Memorial Hwy
Tampa FL 33615
(813) 886-2527**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

Employee signature

Date