SIESTA DENTAL

PATIENT INFORMATION

PATIENT NAME: _____ _____ _____ D.O.B. _____-_____-_____
FIRST LAST M.I.

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: ( ) _____ CELL PHONE: ( ) _____

E-MAIL:_____@_____ SOCIAL SECURITY: _____ - _____- _____

EMPLOYER: _____ PHONE: ( ) _____

EMERGENCY CONTACT & Relationship: _____ PHONE: ( ) _____

Payment type for services rendered today: VISA/MC____ AMEX____ DISC____ CHECK____ CASH____

OTHER:_____

Dental Insurance Policy Holder

INSURANCE COMPANY NAME: _____

PHONE: ( ) _____

INSURED NAME: _____ ID#: _____

RELATION: _____ DATE OF BIRTH: _____

INSURED EMPLOYER:_____

_____ **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand**
Initials **I am solely responsible for any balance not paid by my insurance company**.

PLEASE LET US KNOW HOW YOU HEARD ABOUT US

___Coffee News	___Clipper Magazine	___Harbor Style	___Mature Life Styles
___Scene Magazine	___ Insurance Co.	___ Internet	___Employee
___Natural Awakening	___Parrot Magazine	___Physician & Medical Guide	____BARTER Company
___University Park Guide	___Magnet	___ Value Pack	___Florida Healthcare News
___Peace River Shopper	___Play Golf Sarasota	___Venice Gondolier	___ Neighborhood Networks Publishing
___BNI member	___ Advantage Yellow Pgs	___ Verizon Yellow Pgs	___ Drive by / Walk by
___Attorney's Guide	___Embarq Yellow Pgs	___ Yellow Book	___ TV:_____
___Friend/Relative Name: _____			___ EXPO:_____
___Employee:_____			___ Other:_____

MEDICAL HEALTH HISTORY

Name of physician: _____ Physician's Phone: ( ) _____

Name of previous dentist: _____ Reason for leaving: _____

Do you have or have had, any of the following? Please answer ***YES or NO***

Heart Problems	Yes	No
· Chest Pain		
· Shortness of breath		
· Blood pressure problems		
· Heart murmur		
· Heart Valve problem		
· Taking Heart medication		
· Rheumatic fever		
· Pacemaker		
· Artificial Heart Valve		

Blood Problems		
· Easy Bruising		
· Frequent nose bleeding		
· Abnormal bleeding		
· Blood disease (anemia)		
· Other		

Allergy Problems		
· Hay fever		
· Sinus problem		
· Skin Rashes		
· Taking allergy medication		
· Asthma		
· Ulcers		
· Special diet		
· Constipation		
Pins or metal rods		
· Other_____		

LIST MEDICATIONS YOU TAKE EVERY DAY:

Other	Yes	No
Fainting Spells, Seizures, or Epilepsy		
Diabetes		
Tuberculosis or other respiratory disease		
Cancer/Tumor		
Hepatitis, Jaundice, or Liver Trouble		
Herpes		
HIV-Positive/ AIDS		
Glaucoma		
Have you been hospitalized during the past 5 years?		
Do you have any psychiatric problems?		

During the past 12 mo. Have you taken any of the following?

· Antibiotics or sulfa drugs		
· Anticoagulants		
· High blood pressure		
· Tranquilizer		
· Insulin, Orinase, or similar		
· Aspirin (daily)		
· Digitals or drugs for heart		
· Nitroglycerin		
· Cortisone (steroids)		

Woman

Do you take Contraceptives? _____

Other Hormones? _____

Are you pregnant? _____

If so expected Due Date _____

Are you Allergic to any of the following:

· Local anesthetics		
· Penicillin or other		
Sulfa Drugs		
· Barbiturates, sedatives, or		
· Aspirin		
· Codeine		
· Other		
·		

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health provider or agency who may release such information to you. I will notify the doctor of any changes in my health history or medication.

Patient/Guardian Signature _____ Date: _____/_____/_____

Doctor Signature _____

DENTAL HEALTH HISTORY

The information you provide is important for your dental health. If there have been any changes in your health, ***please tell us***. If you have any questions, do not hesitate to ask. Please answer ***Yes or No*** to the following questions:

	Yes	No		Yes	No
Are you having discomfort?			Are your teeth turning yellow or losing brightness?		
Any sensitivity to hot, cold, sweets, chewing?			Do you smoke?		
Does dental treatment make you nervous?			Do you drink coffee or tea?		

Have you experienced any of the following problems?

	Yes	No
· Snoring Problem		
· Bleeding Gums		
· Bad Breath		
· Grinding teeth		
· Mouth Guard for athletes		

If I could change my smile I would make my teeth:

	Yes	No
Whiter		
Close Space		
Replace stained front fillings		
Change Silver fillings to White		
Repair Chipped teeth		
Other		

Do you have difficulty brushing your teeth due to the following?

	Yes	No
Arthritis		
Difficulty in reaching back teeth		
Uncontrolled hand movement		

Other: _____

	Yes	No
Do you take fluoride supplement?		
Do you prefer to save your teeth?		
Have you had a special coating applied to your back Teeth to protect from tooth decay?		

Date of last cleaning? _____/_____/_____

Have you ever had Periodontal Therapy done? | | |

When?

Denture and Partial Patients:

	Yes	No		Yes	No
Do you wear a Denture/Partial?			If you wear a partial, did you ever break a Clasp?		
How old is your Denture/Partial? _____			Do you use Denture Cleaner?		
Have you relined your Dentures before?			Do you use any product to prevent denture odor?		
Does your denture cause any irritation/soreness?			Are your dentures loose?		
Have your dentures ever broken or cracked?			Do you use any denture adhesive?		

Please explain the reason for your visit to our office today _____
_____

Do you require pre-medication? _____

How many times a day do you brush? _____ **How many times a week do you floss? _____**

What type of toothbrush bristles do you use? Soft_____ Medium _____ Hard _____

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Siesta Dental

Medical Information HIPPA Compliant Release Form

Patient Name: _____ Date of Birth: _____

Release Information

[ ] I authorize Venetian Dental to release or discuss the following:

Appointment Information:

Name: _____ Relationship: _____

Billing / Insurance Information:

Name: _____ Relationship: _____

Medical Information:

Name: _____ Relationship: _____

[ ] Information is not to be released to anyone regarding the above.

➢ This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] My Home [ ] My Work [ ] My Cell Number: _____

If unable to reach me:

[ ] You may leave a detailed message.
[ ] Please leave a message asking me to return your call.
[ ]_____

The best time to reach me is (day) _____ between (time)_____

I acknowledge I have reviewed Venetian Dental Notice of Privacy Practices posted in the waiting room. Copy of privacy notice available upon request.

Patient: _____ DATE: _____

Patient Financial Agreement

Venetian Dental requires all patients to make financial arrangements before we provide treatment.

1. I understand that full payment is due at the time of service for myself or any of my dependents.
2. I understand that it is solely my responsibility to confirm which treatments or procedures are covered by my insurance
   (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums.
3. I understand that as a courtesy Venetian Dental will attempt to verify my insurance coverage from information that I provided and will file two claims per appointment. I am required to pay in full, before treatment is performed, the estimated portion of any procedures or treatment that will not be covered by my insurance.
4. I understand that insurance claims will only be filed if I provide Venetian Dental with my social security and insurance id number (if applicable). If I choose not to provide Emergency Dentistry with my social security number, I understand that I must pay in full for all services rendered. It is Venetian Dental policy to require social security numbers for record keeping purposes even though that may not be the policy of my insurance carrier.
5. I understand that the insurance estimate may differ from what my insurance carrier ultimately pays and that I am responsible for any amounts not paid by my insurance for any reason.
6. I understand that if I discontinue treatment for a requested procedure, including but not limited to, partials, dentures, crowns, bridgework and surgical preparatory work, I remain responsible for paying all lab related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled for discontinued treatment.
7. I understand that all account balances over 30 days will incur an interest charge at the maximum legal rate allowed.
8. I understand that I will be charged the maximum service charge allowed by law for any dishonored check, electronic authorization or any debit sent or provided to Venetian Dental for payment.
9. I understand that I must timely inform Venetian Dental, in writing, of any concerns, questions or disputes I may have concerning my treatment or charges.
10. I understand that if I fail to pay my account in a timely manner, Venetian Dental may report my account to credit rating bureaus or to a collection agency and/or take legal action against me for full payment, including but not limited to all related reasonable attorney's fees, collection and/or court costs.
11. Should the occasion arise where a refund from the office is due to either an insurance company or the patient directly, the process can take up to 30 days to complete.
12. I understand that the charge for copying x-rays is $50.00 and treatment information, per page is $1.00, or the maximum amount allowed by law. These fees are subject to change without notice.
13. Appointment times are reserved specifically per patient and per procedure therefore Venetian Dental requires all appointments to be rescheduled or cancelled at least 24 hours before the scheduled appointment. I understand that Venetian Dental charges $50.00 for any broken or cancelled appointment and/or $100 for any broken or cancelled appointment with a specialist; if cancelled with less than 24 hour notice. Additionally, the first no show or less than a 24 hour notice for any appointment will result in the necessity of securing the next appointment with a credit card. These fees are subject to change without notice.
14. I understand that it is my responsibility to immediately notify Venetian Dental of any changes to my address, phone number, work contact information, work status, insurance changes, etc.
15. I authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. I further authorize Siesta Dental to deposit checks received on my account when made payable in my name.
16. For the safety of our patients and staff we have 24 hour surveillance throughout the office.

✓ **I have thoroughly read, understand and agree to the above terms and conditions.**

_____

Patient Name Printed

_____ _____

Patient / Guardian Signature Date