Patient Registration

Patient Information

First Name: _____ Last Name: _____ Middle Int: _____

Birth Date: _____ Age: _____ Gender: ◯ Male ◯ Female

Marital Status: : ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Soc Sec: _____ Drivers Lic: _____ Email: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

I would like to receive correspondences via ◯ Text Message ◯ Email

Preferred Pharmacy: _____ Phone Number: _____

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Int: _____

Relationship To The Patient: _____

Birth Date: _____ Age: _____ Gender: ◯ Male ◯ Female

Soc Sec: _____ Email: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular: _____

Primary Insurance Information

Policy Holder Name: _____ Birth Date: _____

Ins. Company: _____ Phone Number: _____

ID Number: _____ Group Number: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information

Policy Holder Name: _____ Birth Date: _____

Ins. Company: _____ Phone Number: _____

ID Number: _____ Group Number: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have may have, or medication that you may be taking, could have an important interrelationship with dentistry you will receive. Thank you for answering the following questions.

Patient Name: _____ DOB: _____ Date: _____

Are you under a physician's care now? Yes / No If yes, _____

Are you taking any medications? Yes / No If yes, _____

Have you ever been hospitalized or had major operations? Yes / No If yes, _____

Have you ever had a serious head or neck injury? Yes / No If yes, _____

Have you ever had head and neck radiation? Yes / No If yes, _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? Yes / No **If yes,** _____

_____

Do you use tobacco? Yes / No If yes, _____

Do you use controlled substances? Yes / No If yes, _____

Women: Are you...

○ Pregnant/Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you Allergic to the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Meta ○ Latex ○ Sulfa Drugs ○ Local Anesthetics

○ Other? If yes, _____

Do you have, or have you had any of the following?

○ Unrepaired Cyanotic (CHD) ○ Repaired CHD W/ Prosthetic Device ○ Transplantation Cardiac Valvulopathy

○ Congenital Heart Disease

Do you have the Following?		Fainting Spells/Dizziness	Yes / No	Convulsions	Yes / No
AIDS/HIV Positive?	Yes / No	Kidney Problems	Yes / No	Previous Infective Endocarditis (IE)	
Alzhheimer's Disease	Yes / No	Liver Disease	Yes / No	Yes / No	
Anaphylaxis	Yes / No	Swelling Of Limbs	Yes / No	Recent Weight Loss	Yes / No
Anemia	Yes / No	Chemotherapy	Yes / No	Renal Dialysis	Yes / No
High Blood Pressure	Yes / No	Osteoporosis	Yes / No	Emphysema	Yes / No
High Cholesterol	Yes / No	Pain In Jaw Joints	Yes / No	Epilepsy or Seizures	Yes / No
Shingles	Yes / No	Ulcers	Yes / No	Hives or Rash	Yes / No
Asthma	Yes / No	Previous Clostridioides Difficile(C.Diff)		Sickle Cell Disease	Yes / No
Blood Disease	Yes / No	Yes / No		Sinus Trouble	Yes / No
Breathing Problems	Yes / No	Hemophilia	Yes / No	Leukemia	Yes / No
Low Blood Pressure	Yes / No	Hepatitis A	Yes / No	Bruise Easily	Yes / No
Thyroid Disease	Yes / No	Hepatitis B or C	Yes / No	Lung Disease	Yes / No
Heart Attack/Failure	Yes / No	Angina	Yes / No	Chest Pain	Yes / No
Heart Murmur	Yes / No	Arthritis/Gout	Yes / No	Cold Sores/Fever Blisters	Yes / No
Parathyroid Disease	Yes / No	Excessive Bleeding	Yes / No	Heart Pacemaker	Yes / No
Psychiatric Care	Yes / No	Hypoglycemia	Yes / No	Heart Trouble/Disease	Yes / No
Cortisone Medicine	Yes / No	Irregular Heartbeat	Yes / No	***Have you ever had any serious	
Diabetes	Yes / No	Spina Bifida	Yes / No	illness not listed above?	Yes / No
Drug Addiction	Yes / No	Stroke	Yes / No	If yes, _____	
Rheumatic Fever	Yes / No	Cancer	Yes / No	_____	
Rheumatism	Yes / No	Mitral Valve Prolapse	Yes / No	_____	
Artificial Heart Valve	Yes / No	Tuberculosis	Yes / No	_____	
Artificial Joint	Yes / No	Tumors or Growths	Yes / No	_____	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature of Patient, Parent or Guardian: _____ **Date:** _____

Emergency Contact / HIPPA Consent Form

Emergency Contact

In the event of an emergency, please list who you would like us to contact.

Emergency Contact Full Name: _____

Relation To The Patient: _____

Emergency Contact Phone Number: _____

HIPAA

Please read over our HIPAA policy before filling out this section. By signing this section, you are acknowledging that you have read or received a copy of Palm Harbor Family Dentistry, PA, Notice of HIPAA privacy Policy.

Patient Signature: _____ Date: _____

****If you DO NOT want us to disclose HIPAA information with anyone, Please do not fill out the form below.****

I, _____ authorize and give my consent to Palm Harbor Family Dentistry and any of their staff members and personnel to disclose and discuss my entire dental records with no restrictions, including previous and future changes that may occur with my dental or health treatment with the person I have listed until I give a written notice to stop.

Please list the person you give office consent to disclose your HIPAA information with.

I authorize the office to speak with _____

who's relationship to me is _____

If there is HIPAA information you wish for us NOT to disclose with the name listed above, please list that here _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

****This authorization will remain in effect until a written letter by the patient is received. This will also authorize Palm Harbor Family Dentistry to discuss all dates of treatment unless otherwise stated in writing by the patient.****

Financial Options

Patient Name (PLEASE PRINT) _____ Date _____

Methods Of Payment

1. Cash, Check, Credit Card, Care Credit or Health Flex Saving Card.
2. Dental Insurance, PPO Policy (Described Below)

Dental Insurance

1. We are pleased you have dental insurance, and our office will assist you in obligating the maximum benefits specified in your contract. However, your insurance contract is between you, your employer and the insurance company. Accurate insurance coverage information is required at the time of your appointment, or payment in full will be required.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits if we accept your policy. We will determine to the best of our ability what your deductible and copayment will be. We ask that you pay that amount at time of service. There may be a balance due after the final insurance payment, that you are held responsible to pay that balance in full.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover. If you wish to know if a procedure is covered prior to completion, you can request a predetermination or you can call your insurance provider to confirm coverage.
4. If in the case your insurance company does not pay for a procedure after completion, you are held responsible to pay the remaining balance in full.

Related Information

1. Returned checks and balances older than 90 days may be subjected to additional collection fees.
2. In the event that the account is not paid and we refer the account to collections, you will be responsible for all fee incurred for the collection of your bill (i.e., attorney, court cost and collection agency fees)

Authorization / Acknowledgments

- I have read and understood the information above. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered. To the extent permitted by law, I consent to use and disclose my protected health information (HIPAA) to carry out payment and collection activities.
  Patient Signature _____ Date _____

- I hereby authorize and direct payment of any dental insurance benefits to Palm Harbor Family Dentistry, PA
  Patient Signature _____ Date _____

Same-Day Cancellation / Fail To Attend Appointments

As of September 21st 2020 we have implemented a new office policy regarding same-day cancellations and failing to attend appointments.

- We require a 24-hour notice to cancel appointments.
- If you do not cancel 24 hours prior to your appointment time, you will receive a $25.00 fee added to your account.
- The request to cancel an appointment must be during working hours to give the office an opportunity to fill that appointment.
- If you fail to attend your appointment or show up past your appointment time and we can no longer see you, you will receive a $25.00 fee added to your account.
- The office has a right to refuse scheduling future appointments if you continue to cancel the same day or fail to attend your appointments. The office may require you to call the same-day to schedule an appointment.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____