PATIENT INFORMATION FORM

PIN_____

NAME_____

ADDRESS_____

CITY_____ ST_____ ZIP CODE_____

HOME PHONE_____ CELL PHONE_____

WORK PHONE_____ ext._____

EMAIL ADDRESS_____

****How would you prefer to receive copies of the correspondence that is sent to your dentist?****

☐ **EMAIL** ☐ **TRADITIONAL MAILING**

BIRTHDATE_____

OCCUPATION_____

EMPLOYER_____

PREFERRED PHARMACY_____PHONE_____

PHARMACY ADDRESS_____

GENERAL DENTIST_____ PHONE_____

PHYSICIAN_____ PHONE_____

SPOUSE'S NAME_____ PHONE_____

EMERGENCY CONTACT_____ RELATIONSHIP_____

ADDRESS_____

CITY_____ ST_____ ZIP CODE_____

HOME PHONE_____ WORK PHONE_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?_____

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the financial information form, and completed the information on both sides of this form. I certify that the information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I also hereby authorize Drs. Horvat and Cohen, PLLC, Dr. Scott G. Cohen and Dr. Christina M. Rostant to use and disclose my entire medical record in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed and dated consent shall be as effective as its original. I release, hold harmless, and agree to indemnify the Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

SIGNATURE_____ DATE_____

PARENT (if minor)_____ DATE_____

MEDICAL HEALTH QUESTIONNAIRE

Name_____ Age_____ Height_____ Weight_____

Please describe your general health: ☐ excellent ☐ good ☐ fair ☐ poor
Please list any medicines drugs or antibiotics you are taking: _____

_____

Please list any medicines, drugs or antibiotics to which you are allergic :

Have you ever had an adverse reaction to any drug, anesthetic, or sedative?	☐ yes	☐ no
Have you been a patient in the hospital during the past 2 years?	☐ yes	☐ no
Have you been under the care of a doctor during the past 2 years?	☐ yes	☐ no
Have you ever had excessive bleeding that required special treatment?	☐ yes	☐ no
Have you ever been diagnosed with any immunodeficiency disorder?	☐ yes	☐ no
Is there a history of diabetes in your family?	☐ yes	☐ no
Are you required to restrict your activity or work in any way due to your health?	☐ yes	☐ no
Are you on a special or restricted diet of any kind?	☐ yes	☐ no
Do you have any history of any kind of substance abuse?	☐ yes	☐ no
Do you use tobacco? If so, how much? _____ per day	☐ yes	☐ no
Do you vape? If so, how much? _____ per day	☐ yes	☐ no
Do you use alcohol? If so, how much? _____ per day	☐ yes	☐ no
Have you ever received IV drugs for bone cancer (i.e. Pamidronate, Aredia, Zoledronate/Zometa)?	☐ yes	☐ no
Do you take, or have you taken, drugs for osteoporosis (i.e. Fosamax, Actonel, Zometa, Boniva, Reclast, Xgeva, Alendronate, Evenity, Denosumab, Pamidronate, Prolia)?	☐ yes	☐ no
Do you have a history of cancer? _____	☐ yes	☐ no
Do you have joint replacement? _____	☐ yes	☐ no
*Has a physician directed you to take antibiotics prior to having your teeth cleaned?	☐ yes	☐ no

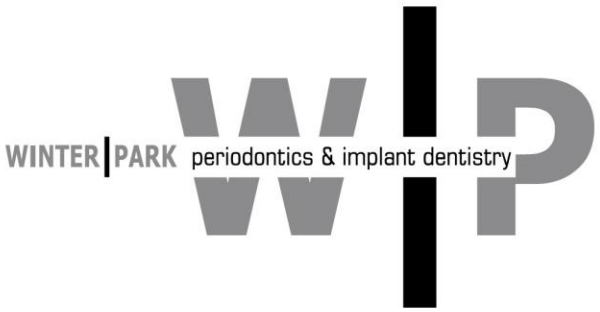
Check any of the following which you may have had:

☐ Heart Trouble	☐ High Blood Pressure	☐ Persistent Cough
☐ Heart Murmur*	☐ Glaucoma	☐ Tuberculosis
☐ Mitral Valve Prolapse	☐ Diabetes Latest A1C _____	☐ Asthma
☐ Heart Surgery	☐ Hepatitis or Jaundice	☐ Sinus Trouble
☐ Rheumatic Fever	☐ Ulcers	☐ Arthritis
☐ Cardiac Pacemaker	☐ Kidney Disease	☐ Stroke
☐ Heart Valve Prosthesis	☐ Psychiatric Care	☐ Epilepsy

Do you have any disease, condition, or problem not listed above that we should know about?

_____

*reviewed by*_____



PIN _____

FINANCIAL INFORMATION

We are committed to providing you with the best possible care, and a clear understanding of our financial policies is important to a good professional relationship. We appreciate you taking the time to familiarize yourself with them.

- Full payment is due at the time of service unless other payment arrangements have been made in advance.
- We accept cash, checks, Visa, Mastercard, Discover, and American Express for your convenience. In some cases, we offer 3rd party credit/payment options.
- We ask that the patient pay the consultation fee at the first appointment. The consult appointment visit along with subsequent surgical treatment will be filed by our office on your behalf. **For periodontal recall/maintenance visits, we will provide you with the insurance filing form upon check out and ask that you submit your receipt and the provided form to your insurance company for reimbursement of routine cleaning appointments.**
- A treatment plan will be generated after your consultation and sent to you before your day of treatment. Typically, we request 50% of the fee to be paid the day of treatment with the remaining balance due after your insurance company has provided their expected benefit or per the agreed upon payment plan.
- If you have insurance, we are out of network and will help you receive the maximum benefits allowed. Insurance coverage, however, is often not as comprehensive as we would like. We are happy to request a benefit estimate from your insurance company to ascertain what coverage may be available. Please remember that we work for you and not your insurance company and we have no legal standing to contest lack of coverage however unfair we feel that it may be.
- Once treatment is completed and the final insurance claim has been submitted, we can wait 45 days for payment from your insurance company. If they have not paid by that time, you are responsible for any balance due. Late payment charges are added to balances left unpaid 90 days after work has been performed.
- Unless canceled at least 2 business days in advance, there is a $75 overhead charge for missed appointments.

Thank you for understanding our office policies. If you have any questions about our fees, financial policies, or any other aspect of your care, please feel free to discuss them with your doctor or the staff.

PRINT NAME _____DATE_____

SIGNATURE _____DATE_____

PARENT (if minor) _____DATE_____

WINTER | PARK periodontics & implant dentistry

PIN_____ DATE_____

DENTAL INSURANCE INFORMATION

Patient's Name:_____Birthdate:_____

Subscriber's Name:_____Birthdate:_____

Subscriber's Sex: Male ☐ Female ☐

Relationship of Subscriber to Patient:_____

Employer of the Subscriber:_____

Subscriber's Social Security:_____

Subscriber's ID:_____

Group Number:_____

Insurance Name:_____

Insurance Address:_____

_____

Phone Number:_____