dental partners of Vero Beach

Comprehensive Dentistry
Airway Orthodontics
& Sleep Solutions
For Patients of All Ages

Adult New Patient Information and Health History

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs.
Please complete the following information so we can best treat you. Thank you

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Birthdate Gender: ❑ M ❑ F Family Status: ❑ Married ❑ Single ❑ Child ❑ Other

E mail Address: _____ Social Security # _____

Phone: _____ _____ _____ _____
Home Work Mobile Other

Address: _____

City _____ State_____ Zip_____

We communicate with our patients through phone, e-mail and texts. Which method would you prefer?
Check all that apply: ❑ House Phone ❑ Cell Phone ❑ E mail ❑ Text Through Cell

Which is the best time to reach you? (Day) _____ Between(time)_____

HOW DID YOU HEAR ABOUT US?

❑ Dental Partner Dentist ❑ Dental Partner Employee ❑ Physician_____
❑ Google/Internet Search ❑ Social Media ❑ Family/Friend ❑ Other _____

Who may we thank for referring you? _____

Which advertisement/event brought you in today? _____

In an EMERGENCY who should be notified? Please enter Name and Phone Number below:

_____

Responsible Party Information ❑ Not applicable

To be completed if the insurance subscriber is other than patient, or if patient is under 18

Name: _____ _____ ____ _____
Last First MI Preferred Name

Title: Gender: ❑ M ❑ F Family Status: ❑ Married ❑ Single ❑ Child ❑ Other
Mr. Ms. Mrs. Etc.

Birthdate: _____ SS# _____ Relationship to patient _____

Phone: _____ _____ _____ _____
Home Work Mobile Other

Address: _____

City _____ State_____ Zip_____

Dental Insurance ❑ Not applicable

Subscriber's Name: _____ _____ ____
Last First MI

Subscriber's Phone # _____ Subscribers SS # _____

Subscribers Birthdate:_____ ID # _____ Group # _____

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: _____ Customer Service Phone_____

By signing this section, I understand that I am seeing an **OUT-OF-NETWORK PROVIDER** and I will be financially responsible for all charges not covered/denied by my insurance. I understand that Dental Partners of Vero Beach is not a Medicaid or Medicare provider and I will assume all financial responsibility for any services rendered. I authorize my insurance company to pay Dental Partners of Vero Beach all insurance benefits rendered. I authorize Dental Partners of Vero Beach to release all information necessary to secure the payment of benefits.

Signature: _____ Date: _____

Medical Insurance

Dental Partners of Vero Beach provides procedures that may be covered under a patient's medical insurance. Please share your insurance information with us so we can determine if your policy would apply. Thank You

Subscriber's Name: _____ _____ ____
Last First MI

Subscriber's Phone # _____ Subscribers SS # _____

Subscribers Birthdate:_____ ID # _____ Group # _____

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: _____ Customer Service Phone_____

By signing this section, I understand that I am seeing an **OUT-OF-NETWORK PROVIDER** and I will be financially responsible for all charges not covered/denied by my insurance. I understand that Dental Partners of Vero Beach is not a Medicaid or Medicare provider and I will assume all financial responsibility for any services rendered. I authorize my insurance company to pay Dental Partners of Vero Beach all insurance benefits rendered. I authorize Dental Partners of Vero Beach to release all information necessary to secure the payment of benefits.

Signature: _____ Date: _____

Pharmacy

Pharmacy:_____ Phone#_____

Address: _____ City: _____

Primary Care Doctor

Dr. Name:_____ Phone# _____

Address: _____ City: _____

Specialty:_____

Date of your most recent physical exam: _____

❑ Permission to forward medical findings and or discuss medical issues with your doctor. Initial _____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash/check/credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for any balance the insurance does not cover. This office will prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. This dental office cannot render services on the assumption that our charges will be paid by insurance.

I understand that the fee estimates for dental care can only be extended for a period of 90 days from the date of the patient examination/consultation/treatment plan.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I understand the above information and agree to its contents. Signature: _____

HIPAA Acknowledgement

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides patients with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Please see the HIPAA Notice of Privacy Practices information that is found in the Patient Center located on our web site prior to signing/submitting your new patient information. You may print the information or receive a copy from our office.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand the above information and agree to its contents. Signature: _____

Medical History

Indicate which of the following conditions you have or have had by checking the box. Check all that apply.

- ❑ Pre-Med required
- ❑ Allergy – Hay Fever
- ❑ Allergy – Penicillin
- ❑ Artificial Joints
- ❑ Blood Pressure, Low
- ❑ Celiac Disease
- ❑ Congenital Heart Def
- ❑ Dizziness/Fainting
- ❑ Head Injuries
- ❑ Heart Valve Replace
- ❑ HIV
- ❑ Liver Disease
- ❑ Nervous Disorders
- ❑ Parkinson's
- ❑ Rheumatic Fever
- ❑ Acid Reflux
- ❑ Allergy – Latex
- ❑ Allergy – Tetracycline
- ❑ Asthma
- ❑ Blood Thinners
- ❑ Chemical Dependency
- ❑ COPD/emphysema
- ❑ Epilepsy
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hypoglycemia
- ❑ Lupus
- ❑ Osteoarthritis
- ❑ Pregnancy
- ❑ Sinus Problems
- ❑ Allergy – Aspirin
- ❑ Allergy – Metal
- ❑ Anemia
- ❑ Blood Disease
- ❑ Boniva Therapy
- ❑ Chemotherapy
- ❑ Dementia/Alzheimer's
- ❑ Fibromyalgia
- ❑ Heart Murmur
- ❑ Herpes
- ❑ Jaundice
- ❑ Mental Disorders
- ❑ Other
- ❑ Radiation Treatment
- ❑ Stomach Problems
- ❑ Allergy – Codeine
- ❑ Allergy – Novocain
- ❑ Arthritis
- ❑ Blood Pressure, High
- ❑ Cancer
- ❑ Cold Sores/Blisters
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Heart Surgery
- ❑ History of Fainting
- ❑ Kidney Disease/Dialysis
- ❑ MS
- ❑ Pacemaker
- ❑ Respiratory Problems
- ❑ Stroke
- ❑ Ever been hospitalized (illness or injury)
- ❑ Taking medication for weight control
- ❑ Subject to frequent headaches
- ❑ FEMALE: Taking birth control pills
- ❑ Presently being treated for any other illnesses
- ❑ Taking dietary supplements
- ❑ A smoker or smoked previously
- ❑ DO YOU SNORE?

Medical History Continued

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Describe any current treatment, impending surgery, or other treatment that may possibly affect your dental treatment: _____

List of all medications, drugs, pills, or herbal remedies, including regular dosages of aspirin. You are welcome to bring a copy of your medications into the office and we would be happy to make a copy for your file.

Dosage	Medication	Dosage	Medication

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. Initial: _____

Dental Information

How would you rate the condition of your mouth?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Previous Dentist name and how long have you been a patient there:

_____

Date of most recent dental exam: _____

Date of most recent dental x-rays: _____

I routinely see my dentist every: ❑ 3 months ❑ 4 months ❑ 6 months ❑ 12 months ❑ not routinely

What is your immediate concern? _____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Personal Dental History (Check all that apply):

❑ Had an unfavorable dental experience
❑ Had trouble getting numb
❑ Had/have braces, orthodontic treatment
❑ Had any teeth removed
❑ Had complications from past dental experience
❑ Had any reactions to local anesthetic
❑ Had your bite adjusted
❑ Other_____

Smile Characteristics (Check all that apply):

❑ Is there anything about the appearance of your teeth that you would like to change?
❑ Have you ever Whitened (bleached) your teeth?
❑ Have you felt uncomfortable or self-conscious about the appearance of your teeth?
❑ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint (Check all that apply):

❑ You have problems with your jaw joint
❑ You have problems chewing
❑ Your teeth changed in the last 5 years, become shorter, thinner, or worn
❑ Your teeth are crowding or developing spaces

Bite and Jaw Joint Con't. (Check all that apply):

- ❑ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- ❑ You clench your teeth in the daytime or make them sore
- ❑ You have problems with sleep or wake up with an awareness of your teeth
- ❑ You Snore
- ❑ You wear or have worn a bite appliance
- ❑ You wear or have worn a C Pap

Tooth Structure (Check all that apply):

- ❑ Cavities within the past 3 years
- ❑ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- ❑ You notice or have holes (i.e. pitting, craters) on the biting surface of your teeth
- ❑ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- ❑ Groves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- ❑ Food gets caught between your teeth

Gum and Bone (Check all that apply):

- ❑ Gums bleed when brushing or flossing
- ❑ Treated for gum disease or were told you have lost bone around your teeth
- ❑ Noticed an unpleasant taste or odor in your mouth
- ❑ History of periodontal disease in your family
- ❑ Experienced gum recession
- ❑ Had any teeth become loose on their own (without injury) or have difficulty eating an apple
- ❑ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:_____

_____

_____

_____

Dental Information Release Form

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

Please provide us with the name(s) and phone number of family and or any other affiliate of yours that you authorize us to discuss and or release patient information to.

_____

_____

- ❑ Please do not release my information to anyone

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant Dental Partners of Vero Beach permission to securely upload my patient information to the web site.

Signature: _____ Date: _____

Broken Appointment Policy

Realizing that we all have busy schedules and that unforeseen situations may occur, we wish to make you aware of the scheduling guidelines for our dental practice. If you find that you are unable to keep your scheduled appointment, we require **2 full business days**' notice in order to prevent a failed appointment fee of **$50.00.** Please understand this is not something we desire to do. I understand the above information and agree to its contents.

Signature: _____ Thank You!

Photograph, Electronic Images and Video Release

Re: Patient_____ DOB: _____

I _____grant permission to Dental Partners of Vero Beach its associates and affiliates, to take photographs, X-Rays, Electronic Images and Videos of me or my child.

Please Note: Photographs, images, X-rays and videos taken during treatment may be used by our laboratories for cosmetic purposes for the fabrication of crowns, bridges or dentures and are a part of your/your child's permanent dental records. In addition to being part of your permanent dental chart photos are extremely important when educating patients and potential patients. We appreciate being able to use photos/images taken for educational purposes. At Dental Partners of Vero Beach we perform unique and specialty services that are best conveyed and shared through photographs/images.

❑ **Dental Chart Images**-I hereby grant Dental Partners of Vero Beach its associates, affiliates, publicity representatives, and representatives of the practice, permission to reproduce, publish, print, use, and distribute copies of such images to be included in my dental/medical chart. Images are used to diagnose and treat dental/medical conditions and may be shared with professional colleagues and educators for the purpose of treatment success. In addition, I grant them permission for my images to be used in medical publications, in the form of prints, slides or film for the use in connection with articles, lectures, and promotional pieces dealing with the head, neck, jaw, dental disorders or cosmetic renovations. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such images without my express consent in each instance. Initial _____

❑ **Education Use**-I agree to allow Dental partners of Vero beach to use my photos anonymously as long as no full faces are shown for the purposes of education, social media or marketing. I waive any right to royalties or other compensation arising from or related to the use of photographs or video. No full face or identifying photo will be taken without your written consent for each photo, unless authorized by this agreement. Initial _____

❑ **Marketing/Social Media Use**- I agree to allow Dental Partners of Vero Beach to use my photos, images and videos, full face view, for the purpose of social media and or other marketing materials, and I waive any right to royalties or other compensation arising from or related to the use of the photographs and or video. Initial _____

❑ **Agree To Have Used Without Personal Review**- I hereby waive any right to inspect or approve the photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown. I waive any right to royalties or other compensation arising from or related to the use of the photographs, images and or video. Initial _____

❑ **I DO NOT AGREE TO USE PHOTOS OTHER THAN DENTAL RECORDS**- Do not use my or my child's photos for social media and or other marketing materials. I understand and agree to allow my images or my child's photos and x-rays to only be used for the purpose of my child's dental treatment and records ONLY. Initial _____

I have read this release before signing below, and I fully understand the contents, meaning and impact of this release.

_____ _____ _____

Print Name (Patient or Guardian) Signature Date