WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____

Birthdate _____

SS#/SIN _____ E-Mail _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Employer _____ Occupation _____

Referred by _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS#/SIN _____ E-Mail _____

Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Car

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name_____ Relationship_____ Work #_____ Home #_____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS#/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS#/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other 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 my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card ____ Visa ____ MC

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

9156/051-1220

Health History

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

A Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ❒ Soft ❒ Medium ❒ Hard

	YES	NO
5. Do your gums bleed while brushing?	❒	❒
6. Do your gums bleed when flossing?	❒	❒
7. Do you feel pain to any of your teeth when brushing or flossing them?	❒	❒
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	❒	❒
9. Have you noticed any loosening of your teeth?	❒	❒
10. Does food tend to become caught between your teeth?	❒	❒
11. Do you have any sores or lumps in or near your mouth?	❒	❒
12. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	❒	❒
b. Pain (joint, ear, side of face)?	❒	❒
c. Difficulty in opening or closing?	❒	❒
d. Difficulty in chewing?	❒	❒
13. Have you had any head, neck, or jaw injuries?	❒	❒
14. Do you have frequent headaches?	❒	❒
15. Do you clench or grind your teeth while awake or asleep?	❒	❒
16. Do you bite your lips or cheeks frequently?	❒	❒
17. Have you ever had:		
a. Orthodontic treatment (braces)?	❒	❒
b. Oral surgery?	❒	❒
c. Gum treatment?	❒	❒
d. Your teeth ground or the bite adjusted?	❒	❒
e. Worn a bite plane or other appliance?	❒	❒
18. Are you satisfied with the appearance of your teeth?	❒	❒
19. Have you ever had an upsetting experience in the dental office?	❒	❒
20. Is there anything about having dental treatment that bothers you?	❒	❒

B 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 may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?	❒	❒
2. Have there been any changes in your general health within the past year?	❒	❒
3. Date of your last physical exam: _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician?	❒	❒
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____	❒	❒
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____	❒	❒
8. Have you ever taken Fen-Phen/Redux?	❒	❒
9. Have you had any abnormal bleeding?	❒	❒
10. Do you bruise easily?	❒	❒
11. Have you ever required a blood transfusion	❒	❒
12. Have you had a recent weight loss?	❒	❒
13. Do you have a persistant cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❒	❒
14. Do you use tobacco?	❒	❒
15. Do you use alcohol or cocaine or other drugs?	❒	❒
16. Are you wearing contact lenses?	❒	❒
17. Do you have any disease, condition or problem not listed above that you think I should know about?	❒	❒
Women Only:		
1. Are you pregnant or think you may be pregnant?	❒	❒
2. Are you nursing?	❒	❒
3. Are you taking birth control pills?	❒	❒

(OVER)

Medical History Continued...

	YES	NO
Are you allergic to or have you had reactions to:		
1. Local anesthetics like novocaine?	☐	☐
2. Penicillin or other antibiotics?	☐	☐
3. Sulfa drugs?	☐	☐
4. Barbiturates, sedatives or sleeping pills?	☐	☐
5. Aspirin?	☐	☐
6. Iodine?	☐	☐
7. Other?_____	☐	☐
Do you have or have you ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	☐	☐
2. Scarlet fever?	☐	☐
3. Heart defect or heart murmur?	☐	☐
4. Heart trouble, heart attack, or angina?	☐	☐
a. Do you have pain in your chest upon exertion?	☐	☐
b. Are you ever short of breath after mild exercise?	☐	☐
c. Do your ankles swell?	☐	☐
d. Do you get short of breath when you lie down?	☐	☐
e. Do you require extra pillows when you sleep?	☐	☐
5. Pacemaker?	☐	☐
6. Heart surgery?	☐	☐
7. High blood pressure?	☐	☐

	YES	NO
8. Low blood pressure?	☐	☐
9. Hepatitis, jaundice or liver disease?	☐	☐
10. Stroke?	☐	☐
11. Sinus trouble?	☐	☐
12. Lung or breathing problems?	☐	☐
13. Asthma or hay fever?	☐	☐
14. Hives or skin rash?	☐	☐
15. Fainting spells or seizures?	☐	☐
16. Diabetes?	☐	☐
17. AIDS or HIV infection?	☐	☐
18. Thyroid problems?	☐	☐
19. Allergies?	☐	☐
20. Arthritis or rheumatism?	☐	☐
21. Joint replacement or implant?	☐	☐
22. Stomach ulcer?	☐	☐
23. Kidney trouble?	☐	☐
24. Tuberculosis?	☐	☐
25. Persistent cough?	☐	☐
26. Cough that produces blood?	☐	☐
27. Cancer?	☐	☐
28. Sexually transmitted disease?	☐	☐
29. Epilepsy?	☐	☐
30. Anemia?	☐	☐
31. Leukemia?	☐	☐
32. Glaucoma?	☐	☐

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

For Completion By The Dentist:

SUMMARY OF DENTAL HISTORY

_____

_____

_____

_____

SUMMARY OF MEDICAL HISTORY

_____

_____

_____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	INITIALS: PATIENT	DENTIST	HYGIENIST

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICALL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment.

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with this practice"

"It is our policy to provide a substitute health care provider, authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit and itemized billing statement to your insurance carrier for the purpose of payment to this practice for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to : preventing or controlling disease, injury of disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues

Research.

We may disclose your health information to researchers conducting research that has been approved by the Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.

We may contact you for marketing purposes of fund-raising purposes as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

"It is our practice to participate in charitable events to raise awareness, food, donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation, or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of practice sponsored fund-raising events"

Change of Ownership.
In the event that this practice is sold or merged with another organization, your information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated though an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree or amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information about your privacy rights, please contact our Privacy Officer by calling this officer.

Complaints
Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (Print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below, read and sign the section at the bottom of the form

○ *WORK TO BE DONE*

I understand that I am having the following work done:
FILLINGS____ BRIDGES____ CROWNS____ EXTRACTIONS____ IMPACTED TOOTH REMOVAL____ GENERAL ANESTHESIA____ ROOT CANALS ____ IMPLANTS____OTHER____

Required *INITIALS____*

○ *DRUGS & MEDICATION*

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction).

Required *INITIALS____*

○ *CHANGES IN TREATMENT PLAN*

I understand that in treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary.

Required *INITIALS____*

○ *REMOVAL OF TEETH*

Alternatives to removal of teeth has been explained to me (root canal therapy, crowns, implants and periodontal surgery, etc) and I authorize the Dentist to remove the following teeth_____and any others necessary for reasons in paragraph # 3. I understand removing teeth does not always remove all infection, if present, and it may be necessary to have further treatment.I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or month) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment the cost of which is my responsibility.

DATE_____ INITIALS____

○ *CROWNS, BRIDGES & GAPS*

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may discolor and come off easily. I understand that I must be careful to ensure that temporary crowns are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap(including shape, fit, size and color) will be before cementation.

DATE_____ INITIALS____

○ *DENTURES, COMPLETE OR PARTIALS*

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures(including shape, fit, size, placement and color) will be at the "teeth in wax" try-in visit. I understand that many dentures require relining approximately 3 to 12 month after initial placement. The cost for this procedure is not included in the initial denture fee.

DATE_____ INITIALS____

○ *ENDODONTIC TREATMENT (ROOT CANAL)*

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

DATE_____ INITIALS____

○ *PERIODONTAL LOSS (TISSUE & BONE)*

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

DATE_____ INITIALS____

I understand that dentistry is not an exact science and that reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient/Guardian: _____ *Date:* _____

BOLD IMAGE DENTISTRY

Andrea Cunningham DMD

620 Malabar Rd Suite 3, Palm Bay, FL 32907 Phone: (321)722-2688 Fax (321)722-2433

Cancellation & Rescheduling of Appointments Agreement

Dear Patients,

In keeping with the busy schedules of both yourself and Bold Image Dentistry, if circumstances arise where an appointment can not be kept, we kindly request 24 hour notice. This will allow us to work around our schedule as well as your own to find a more suitable day and time for your dental needs. In the event of an emergency we will do our best to accommodate your needs.

Rescheduled appointments may be done by the patient or can be done by our office based on business needs. Bold Image Dentistry may contact the patient and ask if the date and or time of the original appointment can be changed, the patient can agree to change or keep the original appointment. If an agreement is made to change date and or time patient is still expected to arrive at the agreed time no more than 10 minutes late to avoid being rescheduled.

Please keep in mind that failure to provide 24 hour notice will result in a $50.00 cancellation fee payable upon your next appointment.

Patient signature _____ *Date* _____

- *Multiple NO CALL NO SHOW or CANCELLATIONS WITH LESS THAN 24 HOUR NOTICE may result in dismissal from this establishment for your dental needs. THANK YOU FOR YOUR KIND COOPERATION.*

Document last revised 10/23/2008

Understanding You're Dental Insurance Claims

Bold Image Dentistry files claims as a professional courtesy to our patients.

A. It is important to know that the money collected at the end of each visit is an estimate.
It is possible that the receipt of certain information may lead to additional charges that your insurance did not cover for various reasons. Some of these reasons include:

1. *Your yearly deductible may not have been met.*
2. *Your yearly maximum may have been reached.*
3. *Your insurance plan excludes certain benefits.*
4. *Our estimation of your portion was incorrect due to incomplete or incorrect information.*

B It is also important to note that Amalgam (Silver) Restorations are not preformed in this office. Most insurance companies will not cover the cost of Composite (White) Restorations on posterior (back) teeth. However, most insurance companies will pay the Amalgam portion toward the Composite filling. You will be held responsible for the difference. Please ask our staff if you have any questions regarding this information.

C. When you receive a notice from your insurance company, we will receive the same notice and reasoning a few days later. Any requests that your insurance company has will be met by our staff. If you have any questions you may call our office but it is not necessary. If there is a balance due after all requirements have been met you will be notified via US mail or during your next visit to our office.

We thank you for choosing Bold Image Dentistry for all your Cosmetic and General Dental needs. We look forward to serving you and please let us know how we can better assist you at any time.

INTIAL _____