Island Dental

FAMILY AND COSMETIC DENTISTRY

About You

Todays Date:_____

Email Address:_____

Name:_____

I prefer to be called:_____ M_____ F_____

Birthdate:_____ Age:_____ SS#:_____ _____

Home Address:_____ Apt/Condo#:_____

City:_____ State:____ Zip:_____

___Single ___Married ___Divorced __Widowed __Separated

Home: (___)_____ Cell: (___)_____

Work: (___)_____ Ext:_____ DL#:_____

Employer:_____

Employer Address:_____

City:_____ State:____ Zip:_____

Whom may we thank for referring you?_____

Whom was your last Dentist?_____

When was your last dental visit?_____

Primary Dental Insurance

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone:_____

ID#:_____ or Policy#:_____

Group #:_____

Insured's Name:_____ _____ Relation:_____

Insured's Birthday:_____ Insured's SS#:_____

Insured's Employer:_____

Secondary Insurance

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone:_____

ID#:_____ or Policy#:_____ Group #:_____

Insured's Name:_____ _____ Relation:_____

Insured's Birthday:_____ Insured's SS#:_____

Insured's Employer:_____

Spouse Information

His / Her Name:_____

Employer:_____

Work: (___)_____ Ext:_____ SS#:_____

Birthdate:_____

Emergency Information

In the event of an emergency, is there someone who lives near you that we should contact:

His / Her Name:_____

Relation:_____

Work: (___)_____ Ext:_____ Home: ( )_____

Person Responsible for Account

Self: □

Name:_____

Work: (___)_____ Ext:_____ Home: ( )_____

Billing Address:_____

Relation:_____ SS#:_____

Employer:_____ DL#:_____

Medical History

Do you have a Physician: ____ Yes or ____ No

Physician's Name:_____

Office #:(___)_____ Date of last visit:_____

Are you currently under the care of a Physician? ____Yes ____No

Please explain:_____

_____

_____

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Medical History (continued)

Your current physical health is: ___Good ___Fair ___Bad

Are you taking any prescription, over the counter or supplement drugs? ___Yes ___No

Please list each one (or provide list of all medications)

Do you smoke or use tobacco in any other form ___Yes ___No

Have you ever taken Phen-Pen (Also known as Redux or Pondimin) ___Yes ___No

If so, when?_____

For Women: Are you taking birth control pills ___Yes ___No

Are you pregnant? ___Yes ___No Number of weeks:_____

Are you nursing? ___Yes ___No

Have you ever had any of the following diseases or medical problems? (please mark all answers)

Yes/No	Yes/No
__/__Alcohol/Drug Abuse	__/__ Heart Surgery/Pacemaker
__/__Allergies/Hay Fever	__/__ Hemophilia
__/__Anemia	__/__ Hepatitis A, B, C
__/__Arthritis	__/__ **High Blood Pressure**
__/__**Artificial Joints/Valves**	__/__ HIV+/Aids
__/__Asthma	__/__ Hospitalized
__/__Bisphosphonate_____	__/__ Jaundice
__/__**Blood Thinner_____**	__/__ Kidney problems
__/__Blood Transfusion	__/__ Liver Disease
__/__Cancer/Chemotherapy	__/__ **Low Blood Pressure**
__/__Congenital Heart Failure	__/__ Mental Disorders
__/__Diabetes	__/__ Mitral Valve Prolap
__/__Difficulty Breathing	__/__ Radiation Treatment
__/__Dizziness	__/__ Respiratory Problems
__/__Emphysema/Glaucoma	__/__ Stroke
__/__Epilepsy/Seizures/Fainting	__/__ Thyroid-Hype/Hypo
__/__Excessive Bleeding	__/__ Tuberculosis
__/__Fever Blisters/Herpes	__/__ Ulcers/Colitis
__/__Heart Attack/Stroke	__/__ Venereal Disease
__/__Heart Murmur	

Are you allergic to any of the following:

Yes/No	Yes/No	Yes/No
__/__Aspirin	__/__Erythromycin	__/__**Penicillin**
__/__Codeine	__/__Metals/Jewelry	__/__Sulfa
__/__Dental Anesthetics	__/__**Latex**	__/__Tetracycline
		__/__Other

Please list any other drugs/materials that you are allergic to:

Dental History

Why have you come to the dentist today?

Do you require antibiotics before dental treatment recommended by your medical doctor? ___Yes ___No

Are you currently in pain? ___Yes ___No

Have you ever had a serious/Difficult problem associated with any previous dental work? ___Yes ___No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/Tmd)? ___Yes ___No

Do you like your smile? ___Yes ___No

Do your gums ever bleed? ___Yes ___No

How many times a day do you brush?_____

How many times a week do you floss?_____

Type of bristles? ___Hard ___Medium ___Soft

Your current dental health is? ___Good ___Fair ___Poor

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

Financial Responsibility:

I further agree to pay all financial charges, collection cost, attorney fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

Signature Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Reviewing Doctor

Signature Date

NOTICE OF PRIVACY PRACTICES

Privacy of your personal information is an important part of our office just as providing you with quality dental care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us.

- Island Dental is required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of Privacy Practices that is described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

- We may use and disclose health information about you for treatment, payment, and health care operations (which does include communication with your dental specialist or physician).

- We will not use your health information for any manner of direct or indirect personal gain or other unauthorized use.

- We may use or disclose your health information when we are required to do so by law.

- We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or the possible victim of other crimes.

- We will not use or disclose your health information for any reason other than those listed without your written authorization.

- We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law.

PATIENT CONSENT

I have reviewed the above information regarding the privacy practices of Island Dental. I consent that Island Dental can collect, use and disclose personal information as set above in the information about the office's privacy policies.

_____ _____

Signature of Patient or Guardian Date

Insurance and Financial Agreement

DENTAL INSURANCE:
Initial each one

_____ We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. We cannot guarantee insurance payments. In the event insurance does not pay, the patient is responsible for all remaining charges. *If you would like to know your insurance benefit prior to treatment being started, we will be happy to file a "pre-treatment authorization" with your insurance company. Keep in mind this is still not a guarantee of coverage.

_____ We will bill your insurance as a courtesy, however, it is the patient's responsibility to know and understand their own dental benefits. If insurance does not pay their "estimated amount" within 60 days, we reserve the right to request payment in full from you. The insurance you have is a legal contract between YOU and the Insurance Company. Ultimately, you are responsible for all charges incurred in our office.

_____ Patient's estimated portion is due the day of service. Every attempt will be made to give accurate estimates; however, the final amount will not be determined until the claim has been processed by the insurance company.

_____ In the event an account is sent to collections, the patient agrees to pay all court costs, attorney fee's, collection costs and office expenses incurred.

PAYMENT OPTIONS:
***Cash, Check or Credit Card:** For your convenience, we accept Visa, MasterCard, Discover and AMEX. There is a $25 returned check fee.

***Payment Plans:** Patient may be eligible for in-office financing. We also offer payment plans through Care Credit.

We believe that your time, as well as, all of our patient's time is important. A $75 fee may be charged for appointments cancelled without a 24 hour notice.

I agree with the above conditions.

Print Name: _____ Date: _____

Responsible Party Signature: _____