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| **Medical History UPDATES** | | | | | | | | | |
| General Health:  Excellent  Good  Fair  Poor | | | | | | | | | |
| **Due to an increase risk of oral Cancer demonstrated in recent studies our office requires that our patients be screened for Oral Cancer.**  Y  N | | | | | | | | | |
| *\*Note: Some insurance plans do not cover this service; please check your plan documents for details.* | | | | | | | | | |
| Y  N | | Under a physician’s care now? | | | | | | |  |
| Y N | | Any hospitalization in the past 5 years? | | |  | | | |  |
| Y  N | | Any serious illnesses/surgeries? | | |  | | | |  |
| Y  N | | Use tobacco in any form? If Yes, Type: | | |  | | | |  |
| Y  N | | Is pre-medication required before dental visits due to heart condition or artificial joint? | | | | | | |  |
| Female Patients: | | | Y N Currently nursing? | Y N Currently pregnant? | | Due Date: |  | |  |
|  | | | | | | | | | |
| Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients?  Y  N If yes, please describe: | | | | | | | | | |
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| Is there anything important about your medical condition we have not asked?  Y  N If yes, please describe: | | | | | | | | | |
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| **All Patients: Do you have, or have you ever had any of the following?** (Check all that apply): | | | | | None |
| Acid Reflux | Bulimia | Hearing Problems | | Psychiatric Treatment | |
| ADHD | Cancer/Malignancy | Heart Attack | | Radiation/Chemo | |
| AIDS/HIV | Cerebral Palsy | Heart Disease | | Respiratory Disease | |
| Anemia | Chemical Dependency | Heart Murmur | | Rheumatic Fever | |
| Anorexia | Chicken Pox | Hepatitis | | Sinus Problems | |
| Anxiety | Convulsions | High Blood Pressure | | Stroke | |
| Artificial Heart Valve | Depression | Kidney Disease | | Thyroid Condition | |
| Artificial Joints | Diabetes | Liver Problems | | Tuberculosis | |
| Arthritis | Dizziness/Fainting | Mitral Valve Prolapse | | Ulcers | |
| Asthma | Epilepsy/Seizures | Mononucleosis | | Venereal Disease | |
| Autism/Asperger’s | ☐ Frequent Ear Infections | Pacemaker | |  | |
| Bleeding Disorder | Frequent Headaches | Other – please list: |  | | |  |

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| **allergies/allergic reactions** | | | | | |
| All Patients: Are you ALLERGIC to or have you ever had any reaction to the following? (Check all that apply): | | | | | |
| Aspirin | Codeine | Lactose Intolerance | Sleeping Pills | None |  |
| Anesthetic – Local | Dairy | Metal Sensitivity | Sulfa Drugs | | |
| Barbiturates | Latex | Nitrous Oxide Sedation | Penicillin/Other Antibiotics | | |
| Other – please list | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |
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| **medication information** | | | | | | | |
| All Patients: Are you currently taking any of the following? (Check all that apply): | | | | | | None |  |
| Antibiotics/Sulfa Drugs | Antihistamines/Allergy | | Daily Aspirin | | Blood pressure Medications | | |
| Blood thinners | Cancer/Chemo Medications | | Cortisone/Steroids | | Heart Medication/Digitalis | | |
| Insulin | Nitroglycerin | | Oral Contraceptives | | Osteoporosis Medications | | |
| Recreational Drugs | Thyroid Medications | | Tranquilizers | | Other Diabetic Medications | | |
| OTC Drugs/ Medications (please list below) | Other (please list below) | |  | |  | | |
| **Drug Name** | | **Dosage** | | **Reason Prescribed** | | | |
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| **patient consent** |
| To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail. |
| Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Patient: Adult Patient Parent Guardian Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Name:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient**:  Self  Parent  Guardian  Other( please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any dependent children under the age of 18 also covered by this acknowledgement:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for the following communications to be used by Tamiami Dental Center:

Cell phone:  Text Message reminders permitted  
  Home phone  Work  E-Mail:

I give permission for Tamiami Dental Center to disclose their identity when calling; to anyone who may answer

my phone. Y N  Other (Please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I grant permission for Tamiami Dental Center to leave a message on:

Home phone  Work Phone

Cell Phone  With any person who may answer when calling the home or cell phone  
  None of the above (Please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I would like the following person(s) to have access to my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **For Office Use Only:** |
| We were unable to obtain the patient’s written acknowledgement of our Notice of Privacy Practices due to the following reason:  The patient refused to sign  Communication barriers  Emergency situation |
| Other – please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DENTAL INSURANCE**

**Dental Insurance Information**

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental Ins. phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Dental Insurance Information**

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental Ins. phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment is due in full at the time of treatment**

*(Unless prior arrangements have been approved)*

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person to contact in case of Emergency:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Written Financial Policy**

Thank you for choosing Tamiami Dental Center. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

**Payment Options:**

You can choose from:

- Cash, Visa, MasterCard, American Express or Discover Card

- Convenient Monthly Payment Options¹ from CareCredit Healthcare & Lending club

* Allow you to pay over time
* No annual fees or pre-payment penalties

Please note:

Tamiami Dental Center requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $500 or more, a 10% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.²

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

Tamiami Dental Center charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

¹Subject to credit approval

²However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.