Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Birth Date: _____ Gender: _____ Marital Status: _____

Email: _____ Social Security #: _____

Phone (Home): _____ (Cell): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

- Name of Dentist: _____ Phone: _____
  City: _____ State: _____

Please answer the following questions regarding your dental history:

Are you having problems now	Y	N
If yes, what? _____		
Is your present dental health poor?	Y	N
Do you wear dentures? (Partials or Full)	Y	N
Would you like to know more about permanent replacements?	Y	N
Are you apprehensive about dental treatment?	Y	N
Have you previously had any periodontal (gum) treatments?	Y	N
Do your gums bleed, or feel tender or irritated	Y	N
Are your teeth sensitive to hot, cold, pressure, sweets?	Y	N
Are you aware of clenching or grinding your teeth?	Y	N
Do you have headaches, earaches, or neck pains?	Y	N
Have you worn braces on your teeth (orthodontics)	Y	N
Do you regularly use dental floss?	Y	N

Have you ever had any of the following? Please answer every question.

AIDS/HIV	Y	N	Dizziness	Y	N	Mental Disorders	Y	N	Codeine Allergy	Y	N
Allergies _____	Y	N	Epilepsy	Y	N	Mitral Valve Prolapse	Y	N	Penicillin Allergy	Y	N
_____	Y	N	Excessive Bleeding	Y	N	Nervous Disorders	Y	N	Erythromycin Allergy	Y	N
Anaphylaxis	Y	N	Fainting	Y	N	Osteoporosis/Osteopenia	Y	N	Aspirin Allergy	Y	N
Anemia	Y	N	Glaucoma	Y	N	Pacemaker	Y	N	Nitrous Oxide Allergy	Y	N
Arthritis/Rheumatism	Y	N	Growths	Y	N	Pregnancy	Y	N	**Latex Allergy**	Y	N
Artificial Joints	Y	N	Hay Fever	Y	N	Radiation Treatment	Y	N	Local Anesthetic Allergy	Y	N
Asthma	Y	N	Headaches	Y	N	Rapid Weight Gain/Loss	Y	N	Materials Allergy	Y	N
Back Problems	Y	N	Head Injuries	Y	N	Rheumatic Fever	Y	N	_____	Y	N
Blood Disease	Y	N	Heart Disease	Y	N	Sinus Problems	Y	N	Other	Y	
Cancer	Y	N	Heart murmur	Y	N	Stomach Problems	Y	N	_____	Y	
Chemical Dependency	Y	N	Hemophilia	Y	N	Stroke	Y	N	_____	Y	
Chemotherapy	Y	N	Hepatitis	Y	N	Surgical Implant	Y	N	_____	Y	
Circulatory Problems	Y	N	High blood Pressure	Y	N	Tobacco Habit	Y	N	_____	Y	
Cortisone Treatments	Y	N	Jaundice	Y	N	Tuberculosis	Y	N	_____	Y	
Cough (Persistent)	Y	N	Jaw Pain	Y	N	Tumors	Y	N			
Cough Up Blood	Y	N	Kidney Disease	Y	N	Ulcers/Colitis	Y	N			
Diabetes	Y	N	Liver Disease	Y	N	Venereal Disease	Y	N			

Have you ever taken any of the following medications?:

Fen Fen/Redux?	Y	N	Effient?	Y	N
Etidronate (Didrontel)?	Y	N	Plavix?	Y	N
Alendronate (Fosamax)?	Y	N	Pradaxa?	Y	N
Ibandronate (Boniva)?	Y	N	Coumadin?	Y	N
Zoledronate (Zometa)?	Y	N	Aspirin (Daily)?	Y	N
Tiludronate (Skelid)?	Y	N	Warfrin?	Y	N
Risedronate (Actonel)?	Y	N	Apixaban (Eliquis)	Y	N
Pamidronate (Aredia)?	Y	N	Rivaroxaban (Xarelto)	Y	N
Densomaub Injections (Prolia)?	Y	N	Other Blood Thinners?	Y	N

- Women: have you ever been diagnosed with or treated for Multiple Myeloma or Breast Cancer? ☐ Yes ☐ No
- Men: Have you ever been diagnosed with or treated for Multiple Myeloma or Prostate Cancer? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Please list all current medications that you are taking?

_____

_____

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Doctor after medical history reviewed with patient

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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 at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

BAY DENTAL SPECIALISTS
Helping Create Healthy Smiles

12904 Racetrack Road
Tampa, FL 33626
(813) 749-7556

CANCELLATION/MISSED APPOINTMENT POLICY

Our office strives to provide optimum treatment and convenience for our patients by offering several specialties in one location. This means however, that each specialist is available only certain days.

Therefore, we ask that you help us by keeping your scheduled appointments, and by notifying our office in advance if you are unable to do so.

We have a waiting list for appointments and when given advance notice we are often able to accommodate other patients.

ALL PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDULED APPOINTMENTS OR WHO CANCEL WITH LESS THAN 24 HOURS ADVANCE NOTICE WILL BE CHARGED A MISSED APPOINTMENT FEE.

- Missed appointment fees are **NOT** covered by insurance plans and are your responsibility to pay.
- If you need to cancel or reschedule an appointment, please give at least **24 hours** notice to avoid a charge.
- If you fail to keep your appointment and have not notified the office 24 hours in advance you will be charged a missed appointment fee.
- If you miss two consecutive appointments, any remaining appointments scheduled will be cancelled and the referring dentist will be notified.

Thank you for your cooperation.

Patient Name (please print): _____

Signature below indicates I have read and understand this policy.

Patient (18 or older) or Legal Guardian Signature: _____

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INSURANCE BENEFIT ACKNOWLEDGEMENT

Your insurance is a method for you to receive reimbursement for the fees you have paid. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on the contract you have with them, not with our office. It is your responsibility to pay deductible, coinsurance, and any other balances not paid by your insurance company.

In determining the amount of benefits payable, your insurance company may give consideration to an alternate procedure that may accomplish a professionally satisfactory result. If an alternate benefit provision is applied to a procedure performed by your dentist and submitted to your insurance company as a claim, the amount of money you owe your dentist may be more than the amount specified on the Explanation of Benefits (EOB).

Estimates of coverage are not a guarantee as eligibility, policy provisions and possible charges from other offices affect payment. Your insurance company may not pay their full estimated portion. **YOU ARE RESPONSIBLE FOR ALL TREATMET CHARGED NOT PAID BY YOUR INSURANCE COMPANY.**

I agree to pay the fees, including any deductible, co-insurance, and any other balances not paid by my insurance company, to Bivens Periodontics and Implant Dentistry.

_____ _____

Signature of Patient/Legal Guardian (if patient is a minor) Date

_____

Patient's Name

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Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**** You May Refuse to Sign This Acknowledgement****

I have been given a copy of this office's Notice of Privacy Practices to review and I am aware that the office has a copy of the Notice available to take with me if I request one.

_____
Please Print Patient's Name

_____
Signature of Patient or Legal Guardian

_____
Date

Due to HIPAA we are unable to release any personal information to anyone without your consent. If you wish Bivens Periodontics and Implant Dentistry to release information to anyone, other than the dentist that referred you to our office, for reasons such as: payment, insurance claims, medical clearance prior to dental procedures, post-operative care, etc. please list those persons below.

1. _____ 2. _____
3. _____ 4. _____

For Office Use Only

We attempted to obtain written proof of Informed Acknowledgement of Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An Emergency Situation prohibited obtaining the acknowledgement
- Other (Please Specify)

_____

_____