Patient Information

Patient Name: _____ Date: _____

Email Address_____

Social Security #: _____ Birth Date: _____Married_____Single_____Other_____

Home Phone _____ Cell Phone_____Work Phone_____

Address_____

_____

Employer Name: _____ Occupation_____

Address_____

Health Information

Date of Last Dental Visit_____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Aspirin Therapy

- 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: _____
- Do you wear a complete denture or a partial denture? Yes___ No___
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- List all medications including Vitamins_____

_____

- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

- How did you hear about us?_____

All of the preceding answers and information are true and correct. I will inform the doctor of any changes immediately.

_____ Date: _____

Signature of patient, parent or guardian

FINANCIAL ARRANGEMENT AND TREATMENT POLICY

We feel that everyone benefits when there is a definite and clear understanding of our treatment and financial policies prior to treatment. They are intended to allow us to be fair to our entire family of patients and help control administrative costs.

APPOINTMENTS

We have exclusively reserved the doctor, staff and facility for your personal dental care. We would appreciate your consideration in giving us a 48 hour notice so that we may effectively re-utilize the time with the doctor or hygienist.

FEES

The fees for your dental treatment are based on the treatment rendered and the time needed to complete the treatment. Our office believes the fees are a fair representation of the standard of care we provide and in-step with industry standard. The fees are an estimate of treatment provided and not a guarantee of payment from the insurance company. Dr. Allen does not guarantee insurance payments. Treatment is based on necessity not on insurance benefits. Treatment plans may change during the course of treatment based on treatment needs. Once treatment has commenced, there are no refunds. A deposit of $250.00 will be required to hold an appointment time over 1 hour in length. This is non – refundable.

INSURANCE

As a courtesy, we will bill your insurance company for treatment rendered, provided we have current and accurate benefit coverage information. Your insurance may contain an alternate benefits clause or there may be procedures that are not covered which may affect the amounts paid by your insurance. It is your responsibility to be aware of these clauses for your particular insurance and the effect on the amounts due. Please understand that your dental insurance is a contract between you and your insurance company and therefore you are responsible for any unpaid balance on your account. We will expect you to pay your deductible and any out-of-pocket portions before services are rendered. If your insurance carrier does not make a payment within 45 days you will be notified. If payment is not received within 60 days we will bill you for any outstanding balance. By law, insurance companies are required to pay each claim within 30 days of receipt. We file all insurance claims electronically so insurance companies receive each claim within days of treatment.

COLLECTIONS

In the event your account is not paid in full within 90 days, the cost for all attorney fees, 65% collection fees and /or cost of litigations shall be incurred by the person responsible for the account**.** * *In addition to the foregoing, the parties agree that the liquidated sum of $500 will be added to any court judgment obtained by Dr. Melanie Allen., P.A., upon rendering of said judgment, for reasonable cost in connection with recording and certifying the judgment and any execution. The patient firmly agrees that, to the extent that any court fails or declines to enforce this immediately preceding provision, Dr. Melanie Allen., P.A., shall be allowed to seek and receive an award of cost of execution as allowed by the law.**The provisions of this agreement are severable. This agreement is intended to be constructed in accordance with its fair meaning, and without regard to the presumption that agreements are to be constructed against draft or. This agreement is to be constructed in accordance with Florida law without regard to Florida's choice of laws provisions. This agreement shall terminate when the patient /responsible party files for bankruptcy.

RETURNED CHECKS

There is a 40.00 charge for any returned checks.

REQUEST FOR COPY OF RECORDS/XRAYS

There is a $35.00 duplication fee per patient for any record/x-ray duplication

Our office would like to thank you for your time, cooperation and trust in us to deliver comfortable, safe and quality dental care to you, your family and friends. We also appreciate your understanding in the necessity of the aforementioned guidelines and procedures. I have read, understand and have received a copy of the following Disclosure Statement. I agree to pay the aforementioned fees.

_____ _____

Patient/ Responsible party signature Date