Palm Dentistry, PLLC

PATIENT REGISTRATION

Patient Name_____ Preferred Name _____ Sex □ M □ F

Social Security # _____Date of birth_____ Home # _____

Address _____ Work #_____

City_____Zip_____ Cell # _____

Driver's License # _____ Email _____

Employer_____ □ Single □ Married □ Widowed □ Divorced/Separated □ Minor

Spouse's Name or Guardian if Minor_____ Spouse/Parent Date of birth _____

Social Sec #_____ Employer_____ Cell/Wk #_____

Emergency contact _____ Relationship _____ Phone # _____

REFERRAL—How did you hear about us? □ Another patient—Name of patient _____

□ Insurance □ Internet □ Google Reviews □ Post card □ ValPak Mailer □ Family are patients □ Other _____

INSURANCE INFORMATION

Name of Insured _____ Insured birth date_____

ID/SS#_____ Insured employer name _____

Dental Ins Comp._____ Ins Phone #_____ Group#_____

2nd Dental Ins (if any) _____ Ins Phone #_____ Group#_____

Address if different from patient _____

AUTHORIZE CONFIRMATION FOR DENTAL APPOINTMENTS

I authorize contact from this office to CONFIRM MY DENTAL APPOINTMENTS via:

□ Cell phone □ Text □ Home Phone □ Work Phone □ Email (please provide) □ Any of the above

I authorize INFORMATION ABOUT MY DENTAL HEALTH be conveyed via:

□ Message on cell □ Message on home phone □ Message on work phone □ In person □ Any of the above

DENTAL HEALTH HISTORY

Date of last dental visit? _____ Dentist's Name _____ Phone _____

Did you have x-rays taken? □ Yes □ No When were x-rays taken? _____

If you could change something about your smile, what would it be? _____

Please check anything you have noticed:

□ Toothache	□ Teeth tender to chew on	□ Bleeding gums	□ Bad breath or taste
□ Spaces developing or food catching between teeth	□ Cracked or lost fillings	□ Change in color of teeth or gums	□ Ulcers
	□ Swelling or lump in mouth	□ Teeth sensitive to hot, cold, sweets	□ Grinding/clenching
□ Pain in jaw or teeth	□ Gum Disease or Pyorrhea	□ Difficulty opening wide	□ Jaw clicks/TMJ

How often do you: Brush daily? _____ Floss daily? _____ Currently wear partials/dentures? □ Yes □ No

Have you had orthodontic treatment? □ Yes □ No If you are currently in ortho treatment, for how long? _____

Are you interested in whitening? □ Yes □ No Do you have your wisdom teeth? □ Yes □ No If yes, are they painful? □ Yes □ No

Please add anything you feel is important for the doctor to know: _____

_____

Patient Name _____ **DOB** _____

GENERAL HEALTH HISTORY

General health (please check) Excellent ☐ Good ☐ Fair ☐ Poor ☐

Physician's Name _____ Phone #_____ Last complete physical _____

Please check any illness you have had and when:

☐ AIDS/HIV	☐ Blood Transfusion	☐ Genital Herpes	☐ Kidney Problems	☐ Rheumatism
☐ Alcoholism	☐ Breathing Problems	☐ Glaucoma	☐ Leukemia	☐ Shingles
☐ Allergies	☐ Cancer	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Alzheimer's	☐ Chemotherapy	☐ Heart Attach/Failure	☐ Low Blood Pressure	☐ Stroke
☐ Anemia	☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Lung Disease	☐ Swelling Limb
☐ Angina	☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Migraines/Headaches	☐ Thyroid
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Tumors
☐ Artificial Heart Valve	☐ Depression	☐ Hepatitis A	☐ Organ Transplant	☐ Ulcers
☐ Artificial Joint	☐ Drug Addiction	☐ Hepatitis B or C	☐ Osteoporosis	☐ Venereal Disease
☐ Asthma	☐ Eating Disorder	☐ Herpes	☐ Paget's Disease	
☐ Bleeding Problems	☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Radiation Treatment	☐ Yellow Jaundice
☐ Blood Disease	☐ Fainting Spells/Dizziness	☐ High Cholesterol	☐ Recent Weight Loss	
☐ Blood Thinner	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Rheumatic fever/disease	☐ _____

Do you have any other health problems or conditions? ☐ Yes ☐ No
If yes, explain _____
Any allergies to: ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Anesthetics ☐ Valium ☐ Demerol ☐ Latex ☐ Other_____

Do you require to take an antibiotic prior to dental visits? ☐ Yes ☐ No If so, why? _____

WOMEN: Are you pregnant? ☐ Yes ☐ No Number of months_____ Nursing? ☐ Yes ☐ No

Are you taking any medications now? ☐ Yes ☐ No Vitamins/supplements? ☐ Yes ☐ No

List of medications _____

Reasons for taking these medications: _____

Have you had a serious illness or operation in the last five years? ☐ Yes ☐ No
If yes, what was it and when? _____

Have you had an orthopedic total joint (hip, knee, other joint) replacement? ☐ Yes ☐ No If yes, when? _____

Has a physician or previous dentist recommended that you take antibiotic prior to your dental appointment? ☐ Yes ☐ No
If yes, what antibiotic and dose? _____

Are you under the care of a specialist? ☐ Yes ☐ No If yes, please explain: _____

Name of specialist? _____ Phone # _____

Do you smoke? ☐ Yes ☐ No
If yes, How much? _____

Do you use tobacco/dip? ☐ Yes ☐ No
If yes, How much? _____

Do you use alcohol? ☐ Yes ☐ No
If yes, How much? _____

Preferred pharmacy name: _____ Pharmacy Phone # _____

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

_____ _____
Signature Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT DATE _____

NAME _____ DATE OF BIRTH _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the used and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

PALM DENTISTRY
1501Presidential Way, Suite 19, West Palm Beach, FL 33401
Office: (561) 684-9990 • Fax: (561) 478-1228

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Authorization to Release Information

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
Printed name Relationship

_____ _____
Printed name Relationship

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent Form, I agree to disclosure of health information as described above.

_____ _____
Signature Printed Name

FINANCIAL POLICY

Our Philosophy is to make patient's lives healthier and more comfortable by providing high quality, compassionate dental care.

In an effort to keep fees reasonable and to continue to provide quality care we have established a payment policy.

Our administrative team will be happy to bill your insurance carrier; however, we do require payment of any uncovered services, deductibles or co-insurance or co-payments to be taken care of at each appointment.

1. All routine dental treatment will be paid in full at the time treatment is rendered.
2. Cash, Check, all Major Credit Cards and Care Credit are all acceptable forms of payment.
3. At least a 50% Deposit of the total treatment plan is required for all Surgical Procedures performed by the doctor at the time the appointment is scheduled. Patients will be advised if a deposit is required.
4. For any appointments that require 2 hours or more may require a deposit for all procedures performed by the doctor at the time the appointment is scheduled.

We have a financial coordinator who will be happy to help you with your individual needs. For patients with insurance, you will be given an ESTIMATE of what your insurance company will pay, and any co-insurance will be handled according to the above financial policy. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Any amount not paid by your insurance is your responsibility.

Anyone paying with a Credit Card and receiving a discount using insurance or discount plan will incur a 4% convenience to their total.

APPOINTMENTS

If you must cancel a scheduled appointment, please notify our office as far in advance as possible **(2 business days office is closed on Fridays)** so that your appointment time may be filled by another patient. **Failure to cancel a scheduled appointment in adequate time will result in a $65 fee for each hour scheduled for hygiene and $100 fee for each hour scheduled for the doctor**. To reschedule an appointment after breaking an appointment, a credit card number or payment is required in advance. If you have an appointment on a Monday, please call no later than Thursday the week before as our office is closed on Friday. This will give our staff enough time to fill the allotted time if needed. All other appointments that require a deposit as stated above require a 24 hour notice or the deposit will be collected for the missed appointment time. A new deposit will have to be paid before rescheduling a new appointment.

I have read and understand the financial policy outlined above.

_____ _____

Signature Date

_____

Printed Name