Palm Tree Dental
Patient Information

Name_____
Age _____ Date of Birth _____Marital Status_____
Address _____ City _____ State _____
Home Phone _____ Cell Phone#_____
Work Phone _____
Email Address_____
Patient's Social Security #_____
Driver's License # _____
Name of Spouse/Parent _____

Name of Dentist _____Phone #_____
Address_____
City _____State_____

Name of Physician _____Phone #_____
Address_____
City _____State_____

Patient Referred by _____
Reason for Visit_____

Employer_____ Employer's Phone #_____
Employer's Address _____
City _____State_____
Employer's Phone # _____

Dental Insurance_____
Name of Insured _____**Relationship to Patient**_____
Date of Birth of Insured_____
Employer_____
Policy ID # _____
Group ID # _____ **Exp. Date** _____

Health and History Form

Are you in good health? Yes___ No___
Do you clench or grind your teeth? Yes___ No___
Are you under the care of a Physician? Yes ___ No___
Have you had Orthodontic treatment? Yes___ No___
Have you had excessive bleeding requiring special treatment? Yes__ No__
Have you had trench mouth? Yes___ No___
Do you have any known drug reaction? Yes___ No___
Have you had Periodontal treatment? Yes___ No___
Prior major surgery or hospitalization Yes _____No ____
Please explain_____
Date of last medical examination_____
Are you taking any drugs or medicine? Yes___ No___
Name_____ Amount_____ Frequency_____
Name_____ Amount_____ Frequency_____
Name_____ Amount_____ Frequency_____

Are you allergic to any of the following:
Local Anesthetics (Novocain) Yes___ No___
Penicillin or other Antibiotics Yes___ No___
Sulfa Drugs Yes___ No___
Barbiturates, Sedatives, Sleeping Pills Yes___ No___
Aspirin, Epinephrine Yes___ No___
Other Drugs:_____

If you have any of the following please circle and date

Heart Failure	Artificial Joint	Stroke
Heart Murmur	Heart Disease or Attack	Anemia
Heart Pacemaker/ Surgery	Angina Pectoris	Leukemia
Hepatitis A (Infectious)	Cancer	Thyroid Disease
Hepatitis B (Serum)	Chemotherapy	Emphysema
Hepatitis C	Blood Transfusion	Arthritis
Kidney Trouble	Yellow Jaundice	Sinus Trouble
High Blood Pressure	Ulcers	Hemophilia
Low Blood Pressure	Tuberculosis	Rheumatism
Respiratory Disorders	Drug Addiction	Cough

Sexually Transmitted Disease (Syphilis, Gonorrhea, Herpes)	Asthma
Cortisone Medicine	Glaucoma
Epilepsy or Seizures	Diabetes Type1
Congenital Heart Lesion	Diabetes Type2
Fainting or Dizzy Spells	Scarlet Fever
Artificial Heart Valve	Rheumatic Fever
Sickle Cell Disease	Hay Fever
Allergies or Hives	Liver Disease
Psychiatric Therapy	Bruise Easily
	AIDS

Do you have any disease, condition or problem not listed above? Yes_ No_
If yes, please explain_____

WOMEN:
Are you pregnant? Yes___No___
Are you taking birth control pills? Yes___No___

To the best of my knowledge, all of the preceding answers are true and correct. If there is a change in my health, or if my medication changes, I will inform the doctor of dentistry at the next appointment without fail. Permission is given to do the dental work agreed upon and to the use of local anesthetics, analgesics, sedatives and X-rays as deemed necessary by the doctor.

_____
Patient's or Guardian's Signature

_____
Doctor's Signature

_____
Date

Palm Tree Dental Center

There are several dental procedures, which you may have heard referred to as "dental cleanings". Some of these procedures are done to prevent periodontal disease from occurring (preventive) while others are done to either stop or reverse the effects of the periodontal disease process (therapeutic). Please remember that those, which are therapeutic, have an additional surcharge according to your schedule of benefits.

ADA CODE 01110 Prophylaxis-Adult (Preventive)

This is a routine cleaning of the permanent teeth of a patient, whose gums are in normal condition with no periodontal disease present. A prophylaxis is a preventive treatment. It includes the removal of plaque and calculus (tartar) from the crown of the tooth above the gum line. Only this dental cleaning is covered at no additional cost.

ADA CODE 04355 Periodontal Scaling in the Presence of Gingival Inflammation (Therapeutic)

The cleaning is used to treat gingivitis, a condition, where the gums have become inflamed or infected. Plaque and calculus (tartar) are carefully removed from the teeth as in a prophylaxis, but because disease is present, this procedure is more time consuming, and often requires more than one appointment. This is a therapeutic treatment, not preventive care, and it has an additional surcharge according to your Schedule of Benefits.

ADA CODE 04341 Periodontal Scaling and Root Planing (Therapeutic)

This procedure removes plaque and calculus (tartar) from both the crown and the root of the tooth. Scaling and root planing is very time consuming and often requires a local anesthetic. This is a therapeutic treatment usually associated with moderate to severe periodontal disease and has an additional surcharge according to your Schedule of Benefits.

ADA CODE 04910 Periodontal Maintenance (Therapeutic)

Periodontal maintenance therapy is an ongoing process following treatment for periodontal disease, which prevents the progression of further disease and maintains the health of the gums. It consists of a series of appointments in which the teeth are re-examined, any new plaque and tartar are removed from the crown and roots and the teeth are polished. The number of follow-up appointments and the interval between them vary from patient to patient. This procedure has an additional surcharge according to your Schedule of Benefits.

Treatment plans are developed according to each individual's oral conditions. The dentist and hygienist will recommend treatment based on what is best for each person. Please do not ask your doctor to provide only the "no extra charge" benefits and therefore neglect treatment, which is not in the best interest of your own oral health.

I, _____ have read and understand the above.

Date_____

Financial Policy and Agreement

Welcome to our office! Our goal is to help remove financial barriers so our patients can receive the dental treatment they need and desire. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask, if you have any questions about our fees, Financial Policy or your responsibility.

Insurance: Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly. Therefore, owing to the complexity of insurance contracts, we can only estimate in good faith, not guarantee coverage. Your estimated patient portion must be paid at the time service is delivered. As a service to our patients, we will bill your insurance company for services, and allow 45 days for them to render payment. After 60 days, you are responsible for the entire balance and it will be due in full. If you have any questions, our courteous staff is always available to answer them.

You will be informed of the treatment planned and associated fees. Patients are responsible for charges for dental services and materials not paid by their dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with the plan prohibiting all or a portion of such charges. To the extent permitted by law, patients consents to the use and disclosure of protected health information to carry our payment activities in connection with filing the dental insurance claim(s). By signing below you are authorizing direct payment of dental benefits, otherwise payable to you, directly to Palm Tree Dental and its authorized dentists.

Payment Options: Patients are asked to pay for services as they are provided. We accept cash, checks, and most major credit cards (MasterCard, Visa, Discover and American Express).

CareCredit®Financing: We offer financing through CareCredit® for those, who qualify. With CareCredit®, you can finance 100% of your dental treatment and there are no upfront costs and no annual fees. CareCredit® also allows for revolving payments with a variable interest rate and up to 12 months of 0% interest. If patient chooses to use Care Credit in conjunction with a discount plan, an administrative fee will apply.

Missed Appointments: We schedule one patient per appointment, because you deserve exclusive, personal time with our doctors and staff. We strive to run on time so you won't be kept waiting, and we ask you to arrive for your appointments on time as well. We understand that you are busy and your time is valuable to us! We pride ourselves on keeping to our

schedule and only deviate from it in the event of dental emergencies. Please call at least two business days in advance to change an appointment. Missed appointments without this notification or repeated cancellations, may incur a **$25.00 cancellation fee**. We want to work with you to schedule convenient appointments for your visits to our office.

Service Charges: The policy of this office is to charge 1% monthly interest (12% annual percentage rate) or a billing charge that will be applied to all accounts over 90 days past due. We will charge $35 for returned and cancelled checks.

Collection Fees: Fees incurred to collect payment will be added to the patient's account holder.

Financial Consent: The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

Patient's or Legal Guardian's Signature _____

Patient's or Legal Guardian's Name (PRINT)_____

Date_____

Notice of Privacy Practices Acknowledgement Medical Release

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may involve in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures or my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact **Palm Tree Dental Center** at any time the address above to obtain a current copy of the Notice of Privacy Practices. If you request copies of your clinical records, we will charge you $1.00 each report page, $5.00 for each film sheet and $15.00 per hour of staff time to locate and to copy your health information, plus postage, if you want the copies mailed to you.

Medical Release

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services or supplies pertaining to me to release true copies of same to PALM TREE DENTAL CENTER or any other insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these patients.

Assignment of Benefits

I hereby authorize my Health Insurance Carrier to make medical benefits payments otherwise payable to me for services rendered by PALM TREE DENTAL, but not to exceed the charges of those services, payable to an mailed directly to: ***Palm Tree Dental Center, 6200 20th Street #292 VERO BEACH FL 32966***

Furthermore, I hereby IRREVOCABLY ASSIGN to PALM TREE DENTAL CENTER the rights and benefits under any policy of insurance, indemnity agreement or any other collateral source as defined in Florida Statues for any service and or charges provided by PALM TREE DENTAL CENTER.
In Witness whereof the undersigned have hereunto set their hands:
Patient's or Legal Guardian's Signature _____
Patient's or Legal Guardian's Name (PRINT)_____
Date_____

Consent For Use And Disclosure Of Health Information

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more detail on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent Form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we do so, we will issue a revised notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent, we may decline to treat you.
You are entitled to a copy of this Consent Form once you sign it.

I,_____ have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care of information to carry out treatment, payment activities and health care operations.
Patient's or Legal Guardian's Signature_____
Patient's or Legal Guardian's Name (PRINT)_____
Date_____

Our Privacy Officer may be contacted at (772) 778-5773

HIPPA Consent for Use / Disclosure of Health Information. This form does not constitute legal advice and covers only federal, not state, law.

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ❑ **The patient refused to sign.**
- ❑ **Due to an emergency situation it was not possible to obtain an acknowledgement.**
- ❑ **We weren't able to communicate with the patient.**
- ❑ **Other** _____

Employee's Signature_____
Date_____