MY PLANTATION DENTIST

Patient Information

Patient's Name: _____ Date _____
Last First Middle

Name of Person filling out paperwork (if other than patient):_____ Relationship:_____

Home Address: _____
Street City State Zip

Home Phone: (____)_____ Cell Phone: (____)_____Work Phone: (____)_____

Email: _____ Birthdate: _____ Social Security No.: _____

Marital Status: ( )Single ( )Married ( )Widowed ( )Divorced ( ) Separated

Employer:_____ Occupation: _____

Work Address: _____
Street City State Zip

Driver's License Number: _____ Driver's License State: _____

Please be prepared to furnish office with driver's license/ID card and insurance card

FINANCIALS / INSURANCE INFORMATION

Policy Holder's Name: _____
Member ID or Social Security No.: _____
Insurance Company: _____ Insurance Co. Phone: _____
Policy Holder's Employer: _____ Group No.: _____

Do you have dual coverage? ( ) NO ( ) YES If Yes, enter secondary policy information here:
Policy Holder's Name: _____ Social Security No.: _____
Insurance Company: _____ Insurance Co. Phone: _____
Policy Holder's Employer: _____ Group No.: _____

REFERRAL INFORMATION

Whom may we thank for your visit today? Patient's name & Relationship: _____

( )Our website ( )Google ( ) Facebook ( )Instagram ( ) Local Chamber ( ) Other(please specify)_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: (____)_____ Cell Phone: (____)_____

Initial _____

DENTAL HISTORY

Patient Name: _____ Date: _____

Reason For your Visit today: _____

Are you Experiencing dental pain or discomfort today? ( )YES ( ) NO

If yes, Location and for how long? _____

Have you seen another dentist or dental specialist within the last 12 months? ( ) YES ( ) NO

Date of last dental exam and Xrays: _____

Date of Last dental cleaning: _____

Have you had any prior bad experiences in a dental office? Please explain: _____

Your current dental health is: ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Have you had any problems with or have been treated for any of the following dental conditions? Circle all that apply.

Bleeding gums	Broken filling/broken tooth	Sensitivity to hot	Bad breath
Periodontal disease	Clenching or grinding	Sensitivity to cold	Bad taste/odor
Deep cleaning/Scaling	Jaw Pain	Sensitivity to sweets	Oral cancer/ Biopsy
Recession of the gums	Click/Pop in the jaw	Sensitivity to biting	Cold sores
Loose teeth	Bruxism	Dry Mouth	Limited opening or Jaw Locking

Aesthetic Evaluation

Are you Happy with your Smile?	YES	NO
Would you like to have whiter teeth?	YES	NO
Would you like to straighten your teeth?	YES	NO
Are you interested in Porcelain Veneers?	YES	NO
Have you had Botox/Dysport/Xeomin and/or Dermal Fillers (Juvéderm/Restylane) in the past?	YES	NO
Would you be interested or want to know more about Botox & Dermal fillers?	YES	NO
Have you heard of PDO threads?	YES	NO
Have you ever heard of Kybella for the removal of submental fat (“double chin”)?	YES	NO

I feel I look (please circle all that apply):

SAD	ANGRY	TIRED	LESS LIVELY	FEARFUL
PAINED	LESS DESIRABLE	OLDER THAN I FEEL	SAGGY	

Initial _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The Health Insurance Portability and Accountability Act (HIPAA) is a law implementing national standards to protect sensitive patient health information from being disclosed without the patients consent or knowledge. This form allows the disclosure & authorization of your personal health information to be released to whom you specify. This may include xrays, treatment plans, financial records and other information pertaining to your records with My Plantation Dentist. In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Patient Name (Print) **Patient Signature**

_____ _____

Legal Representative/Guardian (Print) **Legal Representative / Guardian Signature**

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION OR OTHER SPECIAL SERVICES VIA: (Check All That Apply)

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

Cancellation Policy

We realize that emergencies and other scheduling conflicts arise and sometimes are unavoidable. However, advanced notice allows us to fulfill other patients scheduling needs and keeps the office operating at its most efficient level. Due to our one-on-one treatments, missed appointments are a significant inconvenience to us and other patients.

This policy is in place out of respect for our staff and our patients. Cancellations with less than 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

- Please provide our office with 24 hours notice to change or cancel an appointment. Patients who do not attend a scheduled appointment may be responsible for a $40.00 service charge. This charge cannot be billed to the insurance.

- We reserve your appointment time just for you. We do not double book patients so that we can provide the optimum treatment outcomes for all patients. 24 hour notice will allow us to offer that time to a wait listed patient.

Thank you for providing our office and our patients with this courtesy. I have read, understand and agree to abide by the policy above.

Financial Policy

The My Plantation Dentist team is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility. If you are interested in payment plan options, we have partnered with CareCredit to make it available to you. Please ask a team member if you would like more information.

All treatment recommendations are based on individual need and not insurance coverage. If you have insurance, as a courtesy we will assist you in filing your claim and all necessary paperwork at no charge. Full payment is due at the time of service and/or your patient portion estimated by the system. **Please note that insurance estimations are not a guaranteed payment.** Insurance payment is based on YOUR plan's provisions, available remaining benefit period maximum, and procedure frequency limitations when the claim is received. We are not able to monitor these factors and ask that you be familiar with your plan benefits, maximums and frequencies at all times and before receiving treatment. In all cases, without exception, you are responsible for any amount not covered by your insurance company.

Statement balances are due in full by the due date on the statement. Past due balances are subject to a late fee and a 1.5% per month interest. Should your account remain unpaid, it will be subject to be referred to a collection agency and you will be responsible for additional fees assessed in the process of collecting the unpaid balance. All payments return due to non-sufficient funds will be subject to a $25.00. We thank you for your understanding of our financial policy

Payments may be made by phone, by mail, check, cash, CareCredit, all major creditcards, Apply Pay

Authorization

I consent to diagnostic and dental treatment performed by Dr. Finkelstein, and to the release of information concerning my healthcare, advice and treatment to another dentist for evaluating and insurance claim administration. I consent direct payment of my insurance company to My Plantation Dentist and understand I am responsible in full for any services not paid or covered by my insurance benefits and any account balance. I have had an opportunity to review and agree to the office Financial & Cancellation Policies.

I understand that dentistry is not an exact science, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment or its longevity that I have agreed to for myself or my minor.

I certify that I have read, reviewed and understand the information on this questionnaire and it is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and that the doctor will be using this information to determine appropriate healthful dental treatment. I also understand that I am responsible for notifying the office if this information changes at any time.

Signature _____ Date _____