PLANES
DENTAL ARTS

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ○ Policy Holder ○ Responsible Party - Preferred Name:_____

Patient Information

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Date of Birth: _____ Age: _____ Soc Sec:

_____

Driver's License: _____

Email: _____

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Soc Sec:

_____

Driver's License: _____

○ Responsible Party is a Policy Holder ○ Primary Insurance Holder ○ Secondary Insurance Policy Holder

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Preferred Dentist: _____

Employer ID: _____ Preferred Pharmacy: _____

Carrier ID: _____ Preferred Hygienist: _____

Reason For Visit: _____

Referred By: _____

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Patient Name: _____ **DOB:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following.

Are you under a physician's care now ?	O Yes	O No	If yes: _____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If yes: _____
Have you ever had a serious head or neck injury?	O Yes	O No	If yes: _____
Are you taking any medications, pills, or drugs?	O Yes	O No	If yes: _____
Do you take, or have you taken Phen-Fen or Redux?	O Yes	O No	If yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates?	O Yes	O No	If yes: _____
Are you on a special diet?	O Yes	O No	If yes: _____
Do you use tobacco?	O Yes	O No	If yes: _____
Do you use controlled substances?	O Yes	O No	If yes: _____
Are you required to premedicate prior to dental procedures?	O Yes	O No	If yes: _____
Are you on any blood thinners? (Aspirin, Plavix, Eliquis, etc.)	O Yes	O No	If yes: _____

Women are you .... O Pregnant / trying to get pregnant? O Nursing ? O Taking Oral Contraceptives?

Are you allergic to any of the following?

O Aspirin	O Penicillin	O Codeine	O Acrylic
OMetal	O Latex	OSulfa Drugs	O Local Anesthetics

Other? O If yes: _____

Do you have, or have had, any of the following?

AIDS / HIV	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Arthritis / Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Fainting/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Leukemia	O Yes O No	Stomach Disease	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise easily	O Yes O No	Genital Herpes	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No
Chest pains	O Yes O No	Heart Attack/Failure	O Yes O No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Cold Sores/ Fever Blisters	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Yellow Jaundice	O Yes O No						

Have you ever had any serious illness not listed above? O Yes O No If yes: _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient / Guardian Signature: _____ Date: _____

PLANES
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4755 HWY A1A
Vero Beach, FL 32963
Phone: 772-231-6004

Medical History

Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

Please check any of the below listed medications if you have taken or are currently taking them.

	Trade Name	Generic Name	Administration	Usage
☐	Actonel	Risedronate	Oral	Osteoporosis
☐	Aredia	Pamidronate	IV	Cancer
☐	Bonefos	Clodronate	Oral / IV	Cancer
☐	Boniva	Ibandronate	Oral / IV	Osteoporosis
☐	Didronel	Etidronate	Oral	Pagets
☐	Fosomax	Alendronate	Oral	Osteo / Pagets
☐	Ostac	Clodronate	Oral	Cancer
☐	Skelid	Tiludronate	Oral	Pagets
☐	Zometa	Zoledronic Acid	IV	Osteo / Cancer

I understand that providing incorrect information can be dangerous to me (or patients) health. It is my responsibility to inform the dental office of any change in medical status.

_____ _____

Patient Signature **Date**

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Insurance Assignment and Release

Patient Name: _____

Do you have Dental Insurance? YES / NO

Payment is full is expected if we do not participate with your insurance plan.

If we are a provider for your insurance we will ask that you pay your co-pays at the times of your visits. **If your insurance company has not made a payment to our office within 90 days, you will be required to make payment in full and then seek reimbursement from the insurance company when, and if it pays.**

I certify that I, and or my dependent(s), have insurance coverage with:

_____

Name of Insurance Company (ies)

I understand that I or my dependent(s) are financially responsible for all charges whether or not paid by the insurance. I authorize that use of my signature on all insurance submissions.

_____ _____

Signature of patient or guardian **Date**

_____

Please print name of patient or guardian

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Patient Questionnaire and HIPAA Acknowledgement

Patient Name: _____

You may be contacted by our office to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

May we Contact you at home? **Y / N** Tel. _____

OK to leave voice mail? **Y / N**

May we Contact you at work? **Y / N** Tel. _____

OK to leave voice mail? **Y / N**

May we Contact you via cell phone? **Y / N** Tel. _____

OK to leave voice mail? **Y / N**

Can a message be left with our company name and what the call is in reference to? **Y / N**

Is there anyone we can leave a message with? **Y / N**

(If yes, please list first and last names)

_____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. **Y / N**

(If yes, please list first and last names)

_____

Patient Signature : _____ **Date:** _____

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Financial Policy

As your dentist, we are committed to providing you with the best possible dental care. in order to achieve this goal, we need your assistance and understanding of our payment policy.

Payment is due at the time services are rendered. We accept cash, personal checks, MasterCard, Visa, Discover and American Express. Returned checks are subject to a service charge.

If you do not confirm your appointment with us at least 24 hours before your schedule appointment time, your appointment is subject to cancellation.

Canceled appointments without 48 hours' notice are subject to a broken appointment fee of $85.00

A deposit of 50% will be required for any large cases in which two or more hours of time is reserved with the doctor.

We will gladly discuss your proposed treatment and do our best to answer any questions relating your insurance. You must realize , however, that your insurance is a contract between you , your employer and the Insurance Company. Not all services are a covered benefit in a all contracts. Some insurance Companies arbitrarily select services they will not cover.

If you have any questions about the information or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help you.

I have read and understand the Cancellation and Financial Policy

_____ _____

Patient Signature **Date**

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Commitment Letter

Our Commitment

At Planes Dental arts, we are committed to excellence. We feel that you deserve nothing less when it comes to your health. we use the best materials and techniques available in order to provide you with the quality you have to come to expect from us.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try to communicate all of your dental needs, and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

We understand how valuable your time is, so we make every effort to remain on time. We do not double book our appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

Your commitment

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions , or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Your portion of your treatment is expected at the time of your services. For your convenience we do accept many forms of payments including cash, check, Visa, MasterCard, American Express, Discover as well as third party financing; which includes both interest free and extended financing programs.

Your scheduled appointment is reserved exclusively for you. We have a 48 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require appointments to be rescheduled. We are happy to change your appointment time if a 48 hour notice is given. If sufficient notice is not given, your account will automatically be charged a $85 missed appointment fee. We ask that you make every effort to keep your reserved time.

Patient/Guardian : _____ **Date:** _____

Team Member: _____ **Date:** _____