Fleming Island Center for Dental Excellence

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1845 East West Parkway #3 • Fleming Island, FL 32003 (904)278-7308

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ____________ **Best time to call:** ____________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ____________ ____________
Address 1 Address 2

____________ ____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ____________ **Phone:** ____________

Employer Address: ____________ ____________
Address 1 Address 2

____________ ____ _____-____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ____________________ ____________________ ____ ______________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **Email Address:** ______________________________

Phone: __________ __________ __________ ______ **Best time to call:** ______________
Home Mobile Work Ext

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ____________________ ____________________ ____
Last First MI

Insured's Birth Date: __________ **ID #:** ______________ **Group #:** __________

Insured's Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________

Employer Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________

Insurance Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ______________________ ______________________ ___
Last First MI

Insured's Birth Date: ____________ **ID #:** ________________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **I agree I have read the above conditions of treatment and payment and agree to their content.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER

INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Truth-in-Lending Statement

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

INSURANCE PATIENTS: The percentage of coverage by your insurance company is based on your insurance companys own fee schedule for dental services and may be less than actual charges, resulting in lower coverage for you. We have no control over this situation.

INSURANCE: This is a contract between you and your insurance company. We are not party to this contract. We will file insurance claims as a courtesy to you. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered and non-covered services or usual and customary fees. You are ultimately responsible for all charges whether or not they are paid by your insurance. In some cases your insurance may say they will pay for a certain procedure and then deny payment after the procedure was completed. This is frustrating for you and for us. Payment for the procedure is still due even in these cases.

ASSIGNMENT OF INSURANCE BENEFITS: In the event that you are entitled to any benefits of any type whatsoever arising out of a policy insuring you or another partys liability to you, you hereby assign said benefits to ADVANCED PERIODONTICS to be applied towards your bill. If by chance you received a check from your insurance company for our services you agree to forward the same to our office within five business days.

PAYMENT: All payments are due at the time of services rendered, unless other arrangements have been made in advance. We accept cash, personal check, MasterCard, Visa, and American Express, we also participate with CitiHealth Finance, applications and brochures are available at the front office.

MISCELLANEOUS FEES: There is a $30.00 service charge for returned checks. Also, at the discretion of the Practice, patients may be charged for missed appointments (no show). To prevent miss appointment charges patients must call 24 hours prior to their appointment and cancel. Accounts not paid in full may accrue interest at a rate allowed by law. We also reserve the right at the discretion of the practice, for each billing cycle that your account is outstanding you will be subject to a minimum financial charge of $5 to cover administrative expenses. I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Patient Consent to Receive Mail and /or Telephone Messages

Do we have permission to:

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail. ◯ Yes ◯ No

I give permission to share appointment, billing or dental information with the named below:

____

____

Acknowledgment of Receipt of Notice of Privacy Practices

I have recieved a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

Signature:

____

____

Response Date: ____/____/________