Patient Full Name: ______________________________Nickname: _____________ Age:_____ Date of Birth: _______________

Address: ______________________________________City: __________________ State: ______ Zip: ________

Sex: Male / Female (other) ____________ Social Security #: ______________________

Home Phone (_____)________________Work Phone (_____)_______________Cell Phone (_____)_____________

Email ____

Adult Account Holder for this patient: ________________________________Date of Birth ___________
SS#____________________ Address: ____

Whom may we thank for referring you? ___________________________________

Emergency Contact: _____________________________Relationship: ___________ Phone number: ________________________

Dental Insurance Company _______________Subscriber/Policy Holder ________________ Phone ______________________

Subscriber Social Security Number __________Address____

Employer_______________________________________ID#_________________ Group# ___________________

Is the patient covered by additional insurance? Yes / No/ If yes, list information on back of this page in the order above

Assignment and Release

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party's: insurance carriers, payers, labs and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice (if applicable), and to be applied directly to any outstanding balance on my account.

I understand **that I am financially responsible for "any and all" outstanding balance for services** provided that are not fully covered by insurance, and that I will be billed for this remaining balance. This consists of any treatment started and any fees incurred, including lab fees, even if I fail to complete, said treatment. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I understand the dental practice cannot be held responsible for any services not paid for and/or denied by my insurance company as we are not party to the insurance contract held between you and your insurance company. **I agree to pay all estimated out of pocket expenses on the day of service.**

I have read and understand the above. Any questions I had about this form have been answered and I understand the answer. I attest to the accuracy of the information contained on this page.

Signature of Patient/Guardian/Personal Rep ___________________________________

Printed Name of Patient/Guardian/ Personal Rep _____________________________Date______________

NAPLES VALLEY
DENTAL

Patient's Name ________________________________ Date of Birth __________ Todays Date ________________

Medical History

Are you now under the care of a physician? Yes / No If yes, Physicians name _________________________

If so, for what condition? ________________________

Primary Physician's Name _____________phone __________

Any serious illness, operation or hospitalization in the past 5 Years? Yes/No. If yes, what for? _____________________

DENTAL HISTORY:

Former Dentist __________________ Phone ____________ Date of last Dental visit _________________

HEALTH HISTORY: Circle Yes/No to indicate if you have/had, any of the following:

Liver Disease	Yes/No	Psychiatric Problems (List _______________)	Yes/No
Sores/Blisters on lips or in mouth:	Yes/No	Dry Mouth	Yes/No
Ear Pain	Yes/No	Previous Orthodontic Treatment:	Yes/No
Jaw Pain	Yes/No	Clenching/ Grinding	Yes/No
Previous Periodontal Treatment	Yes/No	Jaw Clicking/popping	Yes/No
Use smokeless Tobacco	Yes/No	Use Cigars/Pipe/Cigarettes	Yes/No
Abnormal Bleeding	Yes/No	Arthritis/Rheumatism	Yes/No
Aspirin Therapy	Yes/No	Asthma or other lung disease	Yes/No
Alcohol Abuse	Yes/No	Alzheimer's/Dementia	Yes/No
Bleeding disorders	Yes/No	Cancer (Type _______________)	Yes/No
Chemical Dependency	Yes/No	Diabetic (Type ______________)	Yes/No
Epilepsy/Seizures, Convulsions	Yes/No	Fainting/Dizziness	Yes/No
Frequent Headaches	Yes/No	HIV+ or AIDS	Yes/No
Hepatitis A B C (circle one)	Yes/No	High Blood Pressure	Yes/No
Low Blood Pressure	Yes/No	Joint Replacements	Yes/No
Pins, plates, rods or screws	Yes/No	Kidney Problems	Yes/No
Radiation Treatment/Therapy	Yes/No	STD's	Yes/No
Sinus Trouble	Yes/No	Thyroid Disease	Yes/No
Congenital Heart Disease	Yes/No	Cardiovascular (heart attack, surgery, Angina…)	Yes/No
Artificial Heart Valve, Pacemaker or stents	Yes/No	Stroke	Yes/No

Name______________________________________ Todays Date _____________

MEDICATIONS:

Are you taking any medicine(s), diet pills, non-prescription,

Vitamins and or supplements, homeopathic or natural

Remedies? List here ____

____

____

(Please attach a separate list of medications if needed)

ALLERGIES:

Are you allergic to or had a reaction to?

Local Anesthetics	Yes / No	Barbiturates (sleeping pills)	Yes / No
Iodine	Yes / No	Metals	Yes / No
Latex	Yes / No	Tetracycline	Yes / No
Aspirin	Yes / No	Penicillin Family	Yes / No
Codeine	Yes / No	Sulfa Drugs	Yes / No
Erythromycin	Yes / No	Others ______________________________________	

FOR WOMAN ONLY:

Are you pregnant or is there any chance you MAY be pregnant Yes / No

Are you Nursing Yes / No

Are you using Oral Contraceptives Yes / No

Please list any other health related conditions, diseases

Or health problems that you think we should be aware of

I understand the importance of a **truthful and complete health history to assist my dentist in providing the best care possible and I have filled this out to the best of my ability.**

Signature of Patient or Guardian _____________________ Printed Name of Guardian ________________________

Office Use Only: Assistant's Initials _____   *Front Desk Initials ______*

Financial Policy

I understand that I am financially responsible for any charges incurred by me from this office. If there are any outstanding balances for services provided that are not fully covered by insurance, I understand that I will be billed for this remaining balance and I will pay this balance within 30 days. I also understand that any remaining balance of over $50 on my account that is not paid in that 30 days, disallows me or my family to be seen for any dental treatment in the office, until that balance is paid in full. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I understand the dental practice cannot be held responsible for any services not paid for and/or denied by my insurance company as we are not party to the insurance contract held between you and your insurance company. I agree to pay all estimated out of pocket expenses on the day of service and agree to a billing fee of $15.00 if not collected by the office at my appointment time. If at any time my check is returned to the office for insufficient funds, I also agree to a charge of $50.00 to cover banking fees associated with my error.

I have read and understand the above. I attest to the accuracy of the information contained on this page.

Patients Name _______________________

Signature of Patient/Guardian/Personal Rep ____________________________________

Printed name of Patient/Guardian/Personal Rep _________________________________

Date _______________________________

X-ray compliance, assignment and release

We will recommend that certain x-rays be taken on a periodic basis as they provide important diagnostic information to detect early stages of decay, oral disease and serious health concerns such as cancer, heart disease, diabetes and other. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend, you will be asked to sign a form refusing the recommended treatment. Be aware that it is office policy that radiographs be done at least every 24 months and your refusal could be detrimental to your patient status. As always, our patient standard of care is our first priority.

I authorize the diagnosis of my dental health by means of radio-graphs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and that I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I understand the dental practice cannot be held responsible for any services not paid for and/or denied by my insurance company as we are not party to the insurance contract held between you and your insurance company. I agree to pay all estimated out of pocket expenses on the day of service.

I, (Patient name) ______________________________ consent to be a patient at Naples Valley Dental and agree to radio-graphics and clinical examinations. I also understand and consent to all of the above contained in this document.

Signature of Patient/Guardian __________________________ Date: _______________________

Reservation/Cancellation Policy

Our Practice is sensitive to busy schedules. We strive to provide high quality dental care in the most efficient manner possible. Because we value your time, we reserve a place for you to see a hygienist, assistant and the dentist. Your reservation helps us ensure we utilize your time most effectively and ensure other patients receive the same quality care that you receive. Your reservation ensures that the time reserved is of supreme quality with our highly credentialed, professional staff.

We do however understand circumstances arise and reservations need to be cancelled or rescheduled. We ask when this situation arises, that you give us at least 48 business hours' notice, ahead of your reservation time, to allow us time to fill the schedule as there are always several patients waiting to be seen. We will work with you to get your appointment rescheduled as soon as possible. Understand that any less than that allowed time will disrupt the quality time other patients can receive and we then reserve the right to charge a late cancellation fee of $35.00 per event. A broke reservation without notice or a "No Show" will result in a $50.00 charge and/or possible dismissal from the practice. This shows a lack of respect and a blatant disregard for our time and of others in our dental family, who value us as their chosen dental provider. You are welcome to call and discuss this with us if this was a true mistake on your part. The fees associated with broke appointments are the responsibility of the patient and or guarantor of the account and must be paid in full before the next family appointment. Cancellation fees in some instances may be waived at the discretion of management as our private, family dental practice firmly believes that a positive provider/patient relationship is based on understanding, good communication and mutual respect.

While we hope all reservations are adhered to at our office, please understand that emergencies arise (both in and out of the office) and schedules may fall behind from time to time. We ask for your patience and understanding that if it were your care that was being attended to and your treatment required the extra time and care, that we would do the same for you and your family as well.

Also be aware that reservation times may shift slightly on occasion to accommodate other changes in our schedules. We will make every effort to notify you either through electronic or direct contact and apologize for any inconvenience that this may cause.

With your permission, the practice will communicate these reservation reminders via text, email and phone calls (which include voice mails) using phone numbers associated with your account. Also, please be aware that if you do not confirm your appointment with our office you will run the risk of being pulled from that days' schedule.

I, (Patient name) ______________________________ understand and consent to be a patient at Naples Valley Dental and agree to the aforementioned information contained in this document.

Signature of Patient/Guardian __________________________ Date____________

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION/HIPAA

I, (patient/guardian name) ______________________________authorize the release of my or my dependent's (patient name) ______________________confidential protected dental information, as described in the AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information. This information may include my dental treatment, condition or information contained within my dental chart and history for purposes of my health care. I also give permission for messages to be left on my voicemail, text and/or e-mail of any listed numbers in my account. I also confirm that I have been offered a copy of the office notice of privacy. The following person (if any), __________________________________ has been granted permission by me to speak and or receive information on me or my dependents on my behalf regarding my dental treatment, diagnosis, scheduling, and billing.

Patient Name ________________________

Signature of Patient/Guardian _________________________

Date____________