Welcome to Sebastian Dental

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Name _____ Social Security #:_____
. *Last Name* *First Name* *Middle Name* *Preferred Name*

Birthdate_____ Sex ❑ M ❑ F Marital status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Address_____City_____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

WOULD YOU LIKE TO RECEIVE TEXT MESSAGE APPOINTMENT REMINDERS? ❑YES ❑NO

WOULD YOU LIKE TO RECEIVE EMAILS FOR CONFIRMATIONS, SURVEYS & NEWS LETTERS? ❑YES ❑NO

MEDICAL AND DENTAL HEALTH INFORMATION

Have you ever had any of the following? Please check all that apply:

❑A-fib	❑Dementia	❑Head Injuries	❑Nervous Disorders
❑AIDS/HIV	❑Diabetes (Type ____)	❑Headaches	❑Mitral Valve Prolapse
❑Allergies	❑Dizziness	❑Heart Disease	❑Osteoporosis
❑Alzheimer's	❑DRUG Allergies:	❑Heart Murmur	❑Pacemaker
❑Anemia	*_____	❑Heart Problems	❑Penicillin Allergy
❑Aneurysm	*_____	❑Hepatitis A B or C	❑Respiratory Problems
❑Arthritis	* _____	❑Herpes	❑Rheumatic Fever
❑Artificial Heart Valve	*_____	❑High Blood Pressure	❑Seizures
❑Artificial Joints	❑Epilepsy	❑HIV	❑Shunt
❑Asthma	❑Epinephrine Sensitivity	❑Jaw Pain	❑Stomach Problems
❑Back Problems	❑Excessive Bleeding	❑Latex Allergy	❑Stroke (Date:_____)
❑Blood Disease	❑Fainting	❑Liver Disease	❑Tuberculous
❑Cancer	❑Glaucoma	❑Mental Disorders	❑Tumors
❑Chemotherapy	❑Growths	❑Migraines	❑Ulcers
❑Codeine Allergy	❑Hay Fever	❑Multiple Sclerosis	❑Vertigo

Whom may we thank for referring you to our practice?_____

Name of Physician: _____ Physician Phone Number:_____

Notify in case of emergency: _____ Relationship to patient: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer Name: _____ Occupation: _____

Date of last dental visit: _____ Reason for this visit: _____

I have reviewed this information and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. This dental office reserves the right to reschedule a patient's appointment if a patient is more than 20minutes late.

Signature *(patient, parent or guardian)*_____ ***Date*** _____

Do you have any dental concerns? ❑YES ❑NO

If yes, please explain: _____

_____

_____

_____

List **ALL** medications (prescribed, over-the-counter, vitamins) you are currently taking and the reason for taking (or please provide a copy of your medication list):_____

_____

_____

_____

_____

List **ALL** known allergies (ie: latex, penicillin, sulfa drugs, environmental): _____

_____

_____

_____

List **ALL** surgeries and hospitalizations and dates (ie: stroke, heart attack, artificial joints, heart valve replacement, emergency care): _____

_____

_____

_____

Have you ever experienced an adverse reaction DURING or AFTER a medical or dental procedure? ❑YES ❑NO

If yes, please explain:_____

_____

_____

Do you have any medical or dental health problems that need further clarification? ❑YES ❑NO

If yes, please explain:_____

_____

_____

Have you ever been told you have gingivitis? ❑YES ❑NO

Have you ever been told you have periodontal disease or seen a periodontist? ❑YES ❑NO

Have you ever had a “deep cleaning”, also known as scaling and root planning? ❑YES ❑NO

How often do you brush? _____ Floss? _____

Do you currently smoke or use smokeless tobacco? ❑YES ❑NO Have you ever in the past? ❑YES ❑NO

How do you feel about the appearance of your teeth? _____

_____

_____

I have reviewed this information and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. This dental office reserves the right to reschedule a patient’s appointment if a patient is more than 20minutes late.

Signature *(patient, parent or guardian)*_____ ***Date*** _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

RESPONSIBLE PARTY INFORMATION

Person responsible for payment: _____
Last Name *First Name* *Initial*

Relation to patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____

City_____ State _____ Zip _____ Phone_____

INSURANCE INFORMATION

Name of Insured: _____ Insured's Birthdate: _____

Name of Insured's Employer: _____ Insured's Relationship to Patient:_____

Name of Insurance Company: _____

Insurance Phone #: _____ Group #: _____ Subscriber #: _____

REMINDER: PLEASE GIVE OFFICE 48 HOURS NOTICE OF NEW DENTAL INSURANCE

Please read the following payment policies before your appointment.

Our office files your insurance as a courtesy.

**If we are an in-network provider for your insurance,
your co-payment and all insurance deductible must be paid at time services are rendered.**

Please note: Each insurance policy is different. It is your responsibility to know your policy. Remember, your insurance policy is a contract between you and your insurance company. It is not a contract between you and our office. It is also your responsibility to let us know if there is a change in your insurance information. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients who carry dental insurance understand that they are responsible to pay the balance remaining after being submitted to insurance.

Please understand that fee **estimates** for dental care are guaranteed for **90 days** unless treatment plan changes.
If you have any questions or are not prepared to pay for your appointment, please notify one of our staff members prior to your appointment. If you are unable to pay for residual balances from previous dates of service, your appointment may be canceled until your balance has been paid.
In consideration for the professional services rendered to you, by the Doctor, you agree to pay the reasonable value of said services to said Doctor, or his/her assignee, at the time said services are rendered. You further agree that the reasonable value of said services shall be as billed unless objected to, in writing, within the time for payment thereof. You 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 you further agree to pay all the costs and reasonable attorney fees if suit be instituted hereunder. Also, you grant permission to our office to be called at home or at work to discuss matters related to this form.

**Self-pay patients are expected to pay in full at time services are rendered.
All emergency dental services, or scheduled dental services, must be paid for at the time services are rendered.**

I have reviewed this information and it is accurate to the best of my knowledge. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature _____ Print Name _____ Date _____

Patient Consent Form for Use and Disclosure of Protected Health Information

By signing this consent form, you give us permission to use and disclose protected health information about you and your treatment, payment and healthcare operations except for any restrictions specified below to which we have agreed. Protected health information is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our HIPAA Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our Notice, the terms of the HIPAA Notice of Privacy Practices may change. If we change our Notice, you may obtain a revised copy. If you would like a copy or have any questions or complaints regarding our HIPAA Notice of Privacy Practices or concerning your protected health information, please let us know.

You have the right to request how restricted health information about you is used or disclosed, for treatment, payment or healthcare operations. We are not required to agree to the restrictions, but if we do, we are bound to our agreement.

If you do not sign this Consent Form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent. We will provide a copy of documentation upon request should you decide not to sign this consent form.

You have the right to revoke this consent, in writing, except where we have made disclosures in reliance on your prior consent.

By signing this consent, you:

*Acknowledge that you have received a copy of the "HIPAA Notice of Privacy Practices".
*Give permission to send a recall card to your home or office.
*Give permission to send billing information to your home or office.
*Give permission to disclose appointment, billing, dental or other protected health information either by phone or documentation with person/people listed below:

Name	*Relationship to Patient*	*Phone Number*
Name	*Relationship to Patient*	*Phone Number*
Name	*Relationship to Patient*	*Phone Number*

I have had full opportunity to read and consider the contents of this Consent form and your HIPAA Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your uses and disclosure of my protected health information to carry out treatment, payment activities and other health care operations.

I understand and agree to the above:

Signature *(patient, parent or guardian)*_____ Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our HIPAA Notice of Privacy Practices, but acknowledgement could not be obtained because:

❑ Individual refuse to sign
❑ Communication barriers prohibited obtaining the acknowledgement.
❑ An emergency situation prevented us from obtaining acknowledgement.