About You (Patient)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name (First) (MI) (Last)

I prefer to be called

Home Address

City State Zip

Phone (Home) (Mobile)

Email

Birthdate SS#

Employer How Long there

Occupation Phone

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact

In the event of an emergency, is there a person you would like us to contact?

Name of contact

Relationship

Phone # Mobile #

Referral Information

How did you hear about us/Who can we thank for referring you?

Dental Insurance

Name of Insurance Company

Group # (Plan, Local, or Policy #)

Insured's Name

Relationship:

Insured's Birth Date

Insured's SS#

Insured's Employer

Office Consents

Please **initial** in each space

Consent of Care

____ I agree and give my consent for Integrated Dental of Florida to provide dental care that is considered necessary and proper in diagnosing and treatment my dental condition. I understand that during RESTORATIVE treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, the most common of which being root canal therapy following routine restorative procedures such as a crown. I give my permission to the dentist to make any/all changes to treatment as necessary in the interest of my oral health.

Cancellation Policy

____ It is the patient's responsibility to give Integrated Dental of Florida a 48-hour notice if they will be unable to attend an appointment. Late cancellations are subject to a $35 per hour for hygiene visits and $50 per hour for restorative procedures. This policy makes it possible for Integrated Dental Arts to offer appointments to all patients in a timely and effective manner.

Deposit Policy

____ Because of our growing patient base and limited schedule availability, Integrated Dental of Florida requires a deposit upon booking any restorative and/or deep cleaning appointment. A deposit of 25% of your estimated patient portion will be collected at time of booking. This deposit is non-refundable if you cancel within our 48-hour cancellation policy or no-show. This policy ensures Integrated Dental of Florida schedule is used wisely and effectively.

Acknowledgement of Receipt of Privacy Practices

____ I acknowledge and agree that I have been informed to read the Notice of Privacy Practices Policy on Integrated Dental of Florida's website. In addition, I acknowledge I can request a copy of Integrated Dental of Florida Notice of Privacy Practices in writing at any time.

INTEGRATED DENTAL

DENTAL HISTORY

Reason for Today's visit: _____

Date of last dental care: _____ Date of last dental X-rays_____

Check (√) if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw/TMJ
- ☐ Food collection between teeth
- ☐ Have periodontal disease
- ☐ You clench/grind your teeth
- ☐ Like to have whiter teeth
- ☐ Loose teeth
- ☐ Periodontal treatment
- ☐ Sensitivity to (circle one):
  Cold Hot Sweets When biting
- ☐ You smoke or use tobacco
- ☐ You vape
- ☐ You have 1 or more missing teeth that you would like replaced
- ☐ Sores or growths in your mouth
- ☐ Have you been diagnosed or think you might suffer from sleep apnea?
- ☐ You have a CPAP
  Do you use it?_____
- ☐ You snore when sleeping
- ☐ You wear a night guard when sleeping
- ☐ You don't like your smile

How often do you floss? _____ | How often do you brush? _____

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Have you ever had any serious illness or operations? _____ If yes, please describe: _____

Have you ever had any blood transfusions? ☐ Yes ☐ No If yes, give approximate date(s):_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you or are you taking Bisphosphonates? ☐ Yes ☐ No Are you taking blood thinners? ☐ Yes ☐ No

Check (√) if you have or have had any of the following:

- ☐ AIDS/HIV+
- ☐ Acid Reflux/GERD
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Auto Immune Disease
- ☐ Back Problems
- ☐ Blood Disease
  - ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems:
  Describe: _____
- ☐ Hemophilia
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ Herpes/Fever Blisters
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Marijuana use
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Other: _____

MEDICATION

List the medication you are currently taking (or provide a copy of your list):

_____

_____

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other _____

_____

_____

_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ **Date:** _____

FINANCIAL/PAYMENT POLICY

We are committed to provide only the best dental care possible. In order to give you the best experience possible, we have found that when everyone is clear on payment for treatment, the confusion and misunderstanding is kept to a minimum. Our main concern is that you receive the proper and optimal treatment necessary to restore and maintain your dental health.

***We ask that you realize that we do NOT work for an insurance company; rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge **will always be based on your individual needs, not your insurance coverage.**

POLICY:

1. Patients are expected to pay for services at the time they are rendered. Our patients who have the benefit of dental insurance are expected to pay the amount of their **estimated** co-insurance at the time of service. Payments may be made using cash, check, Visa, MasterCard, Visa, American Express and/or Discover. A returned check is subject to a returned check fee.
2. As a courtesy to our patients, we offer flexible payment options that can be discussed prior to treatment with our financial team. Options include Care Credit.
3. Deposits will be collected upon booking any restorative and/or hygiene appointment that is lengthy in time and/or services. This ensures that our schedule is utilized in its most effective and efficient way for every patient. The deposit amount will be 25% of the estimated patient portion.
4. If for any reason patients need to cancel or reschedule their appointment, Integrated Dental of Florida must be aware of this within 48 hours of the scheduled appointment time. If 48 hours notice is not given, a $50 per hour fee will be given or the patient forfeits the paid deposit. This also ensures that the schedule is utilized wisely and effectively for every patient.
5. For any unpaid balances, you will receive 3 monthly statements. If Integrated Dental of Florida needs to send out a second statement with no contact from you, a $25 statement fee will be assessed. After 3 statements have gone unpaid, your account will be turned over to collections and you will be responsible for any legal, collection fees and court costs.

Things to remember as a patient with dental insurance:

1. Dental insurance is a benefit to help cover the basic costs of dental treatment; most plans do not cover the true needs of the patient.
2. We offer complimentary benefit checks for patients that we complete at your initial appointment. **Integrated Dental of Florida is not in-network with any dental insurance.** Based on the information your dental insurance company gives us, our finance team can provide you with an **estimate** of your out of pocket cost. This estimate is never a final payment as your insurance dictates what your final payment is once services are billed.

By signing below, you are indicating that you fully understand and accept Integrated Dental Arts financial policy. For the mutual convenience of you and Integrated Dental Arts, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are also patients.

_____ _____

Signature Date

Integrated Dental of Florida HIPAA Disclosure and Privacy Agreement

Integrated Dental respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities.

To ensure that Integrated Dental is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to complete and sign this form. Integrated Dental will keep a copy of your written permission on file.

Please **CIRCLE**:

- I**, DO or DO NOT**, give Integrated Dental permission to leave detailed information on **voicemail** regarding either treatment or finances regarding my dental/medical care.
- I, **DO or DO NOT**, give Integrated Dental permission to **text** detailed messages to my Personal Cell Phone regarding either treatment or finances regarding my dental/medical care.
- I, **DO or DO NOT**, give Integrated Dental permission to email detailed information to my **email address**, regarding either treatment or finances regarding my dental/medical care.

Email Address: _____

I specifically release permission for Integrated Dental to discuss my dental conditions with the following individuals:

1._____Relation: _____

2._____Relation: _____

I am not required to sign this authorization. Integrated Dental does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material.

I am aware that my protected health information will exist forever in either a recorded, printed, and /or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual 's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the Integrated Dental Privacy Officer at 1435 South Tamiami Trail, Suite B, Sarasota, Florida 34239. I understand that Integrated Dental, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Integrated Dental's control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Patient Name: _____

(First) (m. initial) (last)

Signature: _____ Date: _____

For personal representatives, please provide the following:

I, _____, represent that I am the heath care agent/ guardian/ surrogate/ parent of the patient above.

Personal Representative Signature: _____

Address: _____ Phone: _____

*If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient.