Welcome to our practice!

Will you please help us by providing the following confidential information?

PATIENT INFORMATION:

Last Name:_____ First Name:_____

Email Address:_____ Preferred to be called:_____

Date of Birth:_____ Gender: M / F (circle one) SSN#:_____

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

Street Address:_____ City, State, Zip:_____

Driver's License #:_____ ST:_____ Occupation:_____

Employer:_____ Employer Address:_____

Emergency Contact Name:_____ Phone #:_____ Relation:_____

Spouse's Name:_____ Spouse's Contact #:_____

Spouse's Address (if different than above):_____ City, State, Zip:_____

Spouse's Employer:_____ Employer's Address:_____

If we must contact you for scheduling changes, etc., please indicate the PHONE # during business hours to phone you:

Phone Number:_____ Place:_____ Time:_____

How did you hear about our office: ☐ Internet ☐ Patient Referral ☐ Website ☐ TV ☐ Radio ☐ Mailer ☐ Other:_____

If you were a referral, whom may we thank for their trust in us? _____

INSURANCE INFORMATION:

Primary Ins. Company:_____ Phone #:_____

Address:_____ City, State, Zip:_____

Policy Holder Name:_____ Member ID:_____ Birth date:_____

Group # of Policy #:_____

I hereby authorize the release of any information to my insurance company or companies, including records of examination, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Boca Dental of insurance benefits under which I am entitled. **I hereby agree that I am financially responsible for all treatment rendered**, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date:_____ **Patient Signature:**_____

CONSENT:

I hereby authorize Boca Dental to take necessary x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Boca Dental to make a thorough diagnosis of the patient's dental needs, lab needs, and for the use of dental education, which may include full face or smile photos. I waive any claim which might accrue to me personally because of the use of such photographs and/or x-rays. I also authorize Boca Dental to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. **I understand that my dental insurance is a contract between me and the insurance carrier and not between Boca Dental and the insurance company. I fully understand that it is my financial responsibility only, for all dental treatment regardless of insurance coverage.**

Patient Signature:_____ **Date:**_____ **Dr. Signature:**_____

MEDICAL HISTORY

CIRCLE your answers – Do not "X" or "/" or cross through answers – *leave blank if you do not understand the question*

A. GENERAL HEALTH

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year?
   If "Yes" Explain:_____
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years?
4. Yes No Are you being treated by a physician now?
   If "Yes" for what?:_____

Name of your Physician:_____ Date of Last Medical Exam:_____

B. Have you ever experienced:

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of Breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Joint pain, stiffness
14. Yes No Jaundice
15. Yes No Dizziness
16. Yes No Ringing in the ears
17. Yes No Frequent Headaches
18. Yes No Fainting Spells
19. Yes No Blurred Vision
20. Yes No Seizures
21. Yes No Excessive thirst
22. Yes No Frequent urination
23. Yes No Dry mouth
24. Yes No Sleep apnea or chronic snoring

C. Do you have or have you had:

25. Yes No Heart disease/heart murmur
26. Yes No Heart attack, heart defects
27. Yes No Asthma
28. Yes No Rheumatic fever
29. Yes No Stroke, hardening of arteries
30. Yes No High Blood Pressure
31. Yes No TB, emphysema
32. Yes No Hepatitis, A B C
33. Yes No Stomach problems, ulcers
34. Yes No Diabetes
35. Yes No Mitral Valve Prolapse
36. Yes No HIV positive or AIDS-ARC
37. Yes No Tumors, Cancer
38. Yes No Arthritis, rheumatism
39. Yes No Eye disease
40. Yes No Skin disease
41. Yes No Anemia
42. Yes No VD (Syphilis or Gonorrhea)
43. Yes No Herpes
44. Yes No Kidney, bladder diseases
45. Yes No Thyroid, adrenal diseases
46. Yes No History of diabetes, heart problem

D. Do you have or have you had:

47. Yes No Surgeries_____
48. Yes No Blood Transfusions_____
49. Yes No Artificial Joint_____
50. Yes No Contact Lenses
51. Yes No Psychiatric Care
53. Yes No Chemotherapy
54. Yes No Prosthetic hearth valve
55. Yes No Pacemaker
56. Yes No Currently taking birth control pills
57. Yes No Currently pregnant or nursing

E. Do you take or have you taken:

58. Yes No Recreational drugs
59. Yes No Alcohol
60. Yes No Tobacco in any forms
61. Yes No Phen Phen diet pills or any diet pills
62. Yes No Fosamax/Boniva or other Biphosphate drugs

F. Vitamins & Medications

_____

_____

_____

G. ALL PATIENTS

63. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
    If "Yes" Explain:_____
64. Yes No Have you ever been told by a physician or dentist that you need to be pre-medicated with antibiotics prior to any dental treatment for artificial joints or heart conditions?

ALLERGIES: (Please list any and all allergies incl. Latex, Drugs, Foods, Medications, Metals, Jewelry, Acrylics, etc.)

_____

_____

DENTAL HISTORY

CIRCLE your answers – Do not "X" or "/" or cross through answers – *Leave blank if you do not understand the question*

H. Former Dentist:_____ **How long since last visit:**_____

65. Yes No Is keeping your teeth important to you?
    If "Yes" Why?_____
66. _____ On a scale of 1-10 (10 being the best) How would you rate your smile?
67. _____ On a scale of 1-10 (10 being the best) How would you rate your oral health?

I. Have you experienced any of the following:

68.	Yes	No	Bleeding Gums	75.	Yes	No	Sensitivity to Hot & Cold
69.	Yes	No	Bad breath of sour taste in your mouth	76.	Yes	No	Snoring
70.	Yes	No	Burning sensations in your mouth	77.	Yes	No	Food catching between teeth
71.	Yes	No	Soreness in jaw	78.	Yes	No	Clenching of Grinding of Teeth
72.	Yes	No	Is it hard for you to open wide	79.	Yes	No	Pain/Soreness of eyes/ears/face
73.	Yes	No	Clicking or popping in your jaw	80.	Yes	No	Stiff neck muscles
74.	Yes	No	Do you or your parents wear dentures/ partials?	81.	Yes	No	Do you smoke or chew tobacco?

82. Yes No Does having dental treatment make you nervous?
    If "Yes" Why?_____
83. Yes No Is the brightness of your teeth important to you?

If you could change anything about your smile which of the following would you want?

84.	Yes	No	Whiter	90.	Yes	No	Excess showing of teeth
85.	Yes	No	Replace missing teeth	91.	Yes	No	Less Gum showing
86.	Yes	No	Remove stains/spots on teeth	92.	Yes	No	Replace chipped teeth
87.	Yes	No	Straighter	93.	Yes	No	Remove silver fillings
88.	Yes	No	Close space or spaces	94.	Yes	No	Replace old plastic fillings
89.	Yes	No	Replace old crowns	95.	Yes	No	Reshape/resize my teeth

96. Are you experiencing any current dental problem? If yes, please explain:_____
    _____
97. Do you avoid brushing any part of your mouth?_____
98. Are you satisfied with the appearance with the appearance of your teeth?_____
99. Please indicate what is most important when making your dental health decisions
    On a scale of 1-5 (1 = most important / 5 = least important)
    _____ Quality of Care
    _____ Comfort of Care
    _____ Finance and Budget
    _____ Time
    _____ Relationship with Doctor & Staff

Patient Signature:_____ Date:_____

Patient Payment Agreement

Please initial each statement:

_____ I understand that Boca Dental does bill my insurance, if available, and any amount not covered or paid by my insurance is the full responsibility of the patient/guarantor of the said account.

_____ I understand co-payments and/or deductibles, as estimated by any Boca Dental employee, are due prior to treatment commencing or as otherwise stated on this page. Patient co-pay is an estimate of insurance benefits only on treatment and is not a guarantee of payment. Payment of insurance benefits are subject to all terms, conditions, limitations, and exclusions of your insurance at the time the services are completed. I also understand some treatment may be above the insurance contracted fees and/or go beyond my yearly maximum dental benefit and this is an agreement between myself and Boca Dental and I am responsible for these fees. If my contract is terminated or I have not updated any insurance company/coverage with Boca Dental, I am fully responsible to pay for all fees incurred.

_____ I understand that my employer or other 3rd party negotiated my insurance contract, not Boca Dental or its employees. If I have a dispute with my insurance company I will inform my employer and my insurance company.

_____ In the event of upgraded treatment, including but not limited to Emax porcelain and/or any and all upgraded porcelain, lab fees, ribboned/biocore materials, etc. (ribboned/biocore material is a fiber mesh placed and layered inside the structure of the tooth to strengthen the tooth and restoration. It is a dental material and is not an insurance benefits.) I understand and accept that these upgraded fees will not be covered by insurance and I agree to pay for these fees as presented to me by Boca Dental.

_____ I understand that in some cases during a procedure, the treatment plan may change and I may incur additional costs. I also understand that I will be informed of this change during the procedure and I understand I will be responsible for any added cost of the changed treatment.

_____ I understand I will receive a detailed estimation of appointments and treatments and all payments due at each appointment.

_____ Boca Dental has a Cancellation Fee and No Show Policy. Depending on the type of appointment scheduled, fees start at $25 per every hour that was scheduled but missed. In the event you do not show up for your scheduled appointment or give less than 24 hour notice to cancel the appointment, we will charge you a cancelation fee.

_____ I understand the above statements and that I am responsible for all fees incurred in this office whether I have insurance coverage or not.

_____ I understand all information presented to me regarding treatment plans and recommendations, procedures, upgrades and fees due at each appointment.

Patient Signature:_____ Date:_____

HIPAA Privacy Form
Acknowledgment of Receipt of Notice of Privacy Practice

Purpose: This form is used to obtain acknowledgement of our Notice of Privacy Practice or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy/explanation of this offices' Notice of Privacy Practices.
(Print Name)

_____ Date:_____
(Signature of Patient and/or Guardian)

Relationship to Patient: (Circle one) Self or Other:_____

Our Financial Philosophy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, form the start to be perceived as an extension of the dental care we provide you and your family.

Patient's Role
As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone. So that we may file your insurance claims(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to be better serve you in regards to your benefits.

Regarding Insurance:
We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 days.

WE ACCEPT CASH, DEBT, VISA, MASTERCARD, and AMERICAN EXPRESS.
We offer access to extended payment plans with credit approval. I give my consent for a credit check. **Please Initial _____**

I understand that any unpaid balance, after 60 days, is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Boca Dental must take additional steps to collect my account, I will pay ALL costs of collection fees including any court cost and attorney's fees incurred by Boca Dental. I give consent for any credit check to be completed by Boca Dental should it be deemed necessary.

Cancellation Fee: $25/per missed appointment hour scheduled.

I have read the Financial Philosophy. I understand, accept and agree to this Financial Philosophy.

_____	_____	_____	_____
Signature of Patient Responsibility Party	**Date**	**Witness**	**Date**

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers (such as language barrier) prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement at time of service
- ☐ Other (Please specify)