PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Time 8:38 AM

Dental Excellence Of Englewood

New Med History(Copy)

Date 9/16/2021

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you have any, COPD, Sleep Apnea, Respiratory Compromised,Lung Problems?	◯ Yes ◯ No	
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Do you premedicate?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Blood Thinner	◯ Yes ◯ No	COPD	◯ Yes ◯ No				

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

AZOV DENT, INC.

PATIENT FINANCIAL AGREEMENT

Azov Dent, Inc. requires all patients to make financial arrangements with us before we provide treatment.

1. I understand that full payment is due at time of service for myself or any of my dependents.

2. I understand that it is solely my responsibility to confirm which treatment or procedures are covered by my insurance (including, but not limited to, any applicable exclusions, deductibles, annual or lifetime maximums).

3. I understand that as a courtesy, Azov Dent, Inc. will attempt to verify my insurance coverage from information that I provided and will file two (2) claims per appointment. I am required to pay in full, before treatment is performed, the estimated portion of any procedure/s or treatment that will not be covered by my insurance.

4. **I understand that my insurance claims will only be filed if I provide Azov Dent, Inc. with my social security and insurance ID number (if applicable)**. If I choose not to provide Azov Dent, Inc. with my social security number, I understand that I must pay in full for all services rendered. It is Azov Dent, Inc's policy to require social security numbers for recordkeeping purposes even though that may not be the policy of my insurance carrier.

5. I understand that the **insurance estimate may differ from what my insurance carrier ultimately pays** and that I am responsible for any amounts not paid by my insurance for any reason.

6. I understand that if I discontinue treatment for a requested procedure, including but not limited to, partials, dentures, crowns, bridgework and surgical preparatory work, I remain responsible for paying **all lab costs** for materials and services that were incurred before I discontinue treatment.

7. I understand that I will be charged ($30.00) the maximum service charge allowed by law for any dishonored check, electronic authorization or any debit sent or provided to Azov Dent, Inc. for payment.

8. I understand that I must timely inform Azov Dent, Inc., in writing, of any concerns, questions or disputes I may have concerning my treatment or charges.

(Initial)

9. I understand that unless patient records are sent directly to another provider, the charge for copies of x-rays is $10.00 and treatment information is $5.00 or the maximum amount allowed by law.

10. I understand that Azov Dent, Inc. currently may charge $25.00 for any broken appointment, and this fee is subject to change without notice.

11. I understand that it is my responsibility to **immediately** notify Azov Dent, Inc., of any changes to my address, phone number, work contact information, work status, insurance changes, etc.

12. I authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. I further authorize Azov Dent, Inc. to deposit checks received on my account when made payable in my name.

13. I understand that all account balances **over 30 days** will incur an interest charge at one and a half percent (1 1/2%) per month. I understand that if I fail to pay my account in a timely manner, Azov Dent, Inc. may report account to credit rating bureaus or to a collection agency and/or take legal action against me for full payment, including but not limited to all related reasonable attorney's fees, collection and/or court costs. I understand that after **90 days** all account balances will be subject to a **25% collection fee for non-payment**.

14. Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment so we ask that you kindly give us a minimum of 2 business days notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If 2 or more appointments are broken in a 12 month period without 2 business days notice, a cancellation fee of $50.00 will be applied to your account and if necessary, all future appointments will be cancelled and patients will be placed on a "priority list" for their next visit.

I have thoroughly read, understand and agree to the above terms and conditions.

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(Signature of Patient or Guardian) (Date)

Azov Dent, Inc. reserves the right to the following:**interest charges will accure on balances that have not been paid on the 30th day after the biling date. Late payment fees and returned check fees, if any, are not included in the daily/mothly balance. The interest rate imposed by Azov Dent, Inc. shall be 18% per annum or the highest rate permitted under the applicable law of Florida. Your payment to any outstanding balance may be allocated in a manner which Azov Dent, Inc. determines and is legally allowed, and may change from time to time. Azov Dent, Inc. reserves the right to apply payments to balances with lower interest rates. 02/20/2008- Azov Dent, Inc.

Dental Excellence of Englewood
HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____

Date of Birth: _____

I. My Authorization

I authorize use or disclose the following health information.

☐ All of my health information

☐ My health information relating to the following treatment or condition:

_____

☐ Other:_____

The above party may disclose this health information to the following recipient:

Name _____Phone _____

Name _____Phone _____

The purpose of this authorization is

☐ At my request

☐ Other: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission

Signature of Patient: _____ Date: _____

Azov Dent, Inc.

HIPAA ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF OUR ADHERANCE TO STATE AND FEDERAL PATIENT PRIVACY PRACTICES

Please be advised that AZOV DENT, INC. will only use your personal and health information that is retained in your patient chart for professional communications. We will file insurance information electronically and/or via U.S. Mail within the same privacy guidelines.

We will at no time make available your personal or health information to any outside sources.

The undersigned acknowledges receipt of the current Notice of Privacy Practices at Azov Dent, Inc.

Date: _____

Please Print Name: _____

Please Sign Name: _____

ADDENDUM

As a convenience, authorization may be given for a designated representative to make or change appointments, and/or obtain information.

Authorized Representative: _____ **PH #:** _____
Patient Signature: _____

Should you have questions regarding this Privacy Policy, please contact our Privacy Policy Officer, Patricia A Johnson, Compliance Manager.

FOR OFFICE USE:

I have attempted to obtain the patient's (or representative) signature on this acknowledgement but did not because:

- ☐ It was an emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because _____
- ☐ Other: _____

Signature of Azov Dent, Inc. Representative: _____

Understand Insurance Benefits

In order to accommodate the needs and requests of our patients, Englewood Dental Excellence does file dental insurance. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon what type of contract your employer negotiated with that carrier on your behalf.

It is the insured person's responsibility to understand their benefits. We do not wish that your insurance company comes between you and your doctor. You must do your part in understanding the limitations of insurance policies and what your company has purchased for you. Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000. There has been no significant increase in the yearly maximum cap in 40 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary." Our fees reflect the quality you receive.

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will get back only what your employer has put in, less the insurance company's profit margin.

Insurance companies do NOT cover many routine and newer dental services. We bill your insurance as a courtesy. If insurance does not pay within 60 days, Englewood Dental Excellence reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and YOUR insurance company. Ultimately, you are responsible for all charges incurred in our office.

If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and we subsequently complete services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day or has a waiting period, or a missing tooth clause, your carrier will probably deny payment for services received. Englewood Dental Excellence can only estimate what your carrier will pay on a specific treatment, if your insurance carrier pays a lesser amount than estimated you will be billed for the difference. It is your responsibility to keep up with the maximum amount of benefits you have used in a calendar year. Please remember that you, the patient, are ultimately responsible for payment on your account.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. We hope you will choose the best that dentistry has to offer.

I have read, and understand, and accept the terms of the about outlined policies for insurance and financial commitments that may incur as a result of treatment at Englewood Dental Excellence.

Signature_____

Date_____

WELCOME TO OUR OFFICE!

Please tell us how you heard about Dental Excellence of Englewood: Please check one:

_____ Facebook

_____ Englewood Review

_____ Patient/Friend

_____ Insurance

_____ Internet/Google

_____ Yelp/Phone Book

_____ News letter in mail

_____ Walk-in

ARTIFICIAL JOINT

Do you require antibiotics before dental procedures? Yes____ No_____

What replacement did you have? _____

Orthopedic surgeon _____

Phone#_____ Fax#_____

Antibiotic you were told to take_____

Dosage_____ Quantity_____

CANCER

Oncology Doctor_____

Phone#_____ Fax#_____

Did you have Chemotherapy or Radiation? Yes_____ No_____

How Often? _____

Have Bisphosphonates been used during treatments (oral or IV)

Yes___ No____

HEART RELATED ISSUES

Cardiologist_____

Phone#_____ Fax#_____

Cardiac Event_____

Blood Thinner: How many days prior to dental treatment do you stop? _____

PAIN MANAGEMENT

Doctor_____

Phone#_____ Fax#_____

What medications are you allowed to take: NSAIDS____ Alieve___Ibuprophen___

Others_____

SIGNATURE_____ DATE_____