South Florida Sedation Dentistry

Patient Information

Today's Date_____

First Name_____MI_____

Last Name_____

Birthdate_____Age____SS#_____

_____Married _____Single _____Other

Address_____

City_____State_____Zip_____

Home #_____Cell #_____

Employer_____Work #_____

Occupation_____

EMAIL_____

Referred By_____

Responsible Party

First Name_____MI_____

Last Name_____ ___M ___F

Birthdate_____ Age_____ SS#_____

Employer_____Work #_____

Occupation_____

Employer's Address_____

_____

Primary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address_____

Insurance Co. Phone_____

Plan_____Group_____Policy_____

Policy Owners Name_____

Relationship to Patient_____

Policy Owners Birthdate_____

Policy Owners Employer_____

Employees Address_____

Orthodontic Coverage? ____Yes ____No

Secondary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address_____

Insurance Co. Phone_____

Plan_____Group_____Policy_____

Policy Owners Name_____

Relationship to Patient_____

Policy Owners Birthdate_____

Policy Owners Employer_____

Employees Address_____

Orthodontic Coverage? ____Yes ____No

Dental History

Purpose of today's visit_____

Previous dentist_____

When was your last visit_____

What was done_____

Last Cleaning_____

How often do you brush_____

Do you have any of the following: ____Bleeding gums

____Sensitive teeth ____Loose teeth ____Broken fillings

____Jaw pain _____Injuries to teeth _____Other

Explain_____

Unpleasant dental experience ____Yes ____ No

Have you ever had: ___Orthodontics ___Gum treatment

___Root canal ___ Crowns ___Veneers ___ Implants

___Oral surgery ___Other: Explain_____

Are you happy with the appearance of your teeth?

___Yes ___No ___Color ___Position ___Smile

Have you ever had tooth whitening? ___Yes ___No

___In Office ___Overnight ___Drug store

Are you interested in replacing missing teeth? ___Yes ___No

Which method: ___Dentures ___Bridges ___Implants

Do you have any questions for Dr. Senft? ___Yes ___No

_____

To the best of my knowledge the information provided above is accurate. I will update the office regarding any changes in this information.

Patient/Guardian Signature _____ Date _____

Medical History

Physicians Name_____

Office Address_____

Physicians Phone #_____

Are you currently under the care of a physician? ___Yes ___No

Women: Are you currently pregnant? ____Yes ____No

Has there been a recent change in your health? ___Yes ___No

Explain_____

Are you currently taking any prescription, over the counter, or recreational drugs? . . . . . ___Yes ___No

List Medications:_____

_____

_____

Have you ever been advised to pre-medicate with antibiotics prior to dental visits? ___Yes ___No _____

Have you been hospitalized or had serious illness within the past two years? . . . . . ___Yes ___No

Explain_____

Please mark any allergies/adverse reactions:

Y N Penicillin
Y N Tetracycline
Y N Erythromycin
Y N Sulfa
Y N Local Anesthetics
Y N Codeine
Y N NSAID (Advil/ Motrin)

Y N Aspirin
Y N Valium
Y N Barbiturates
Y N Latex
Y N Iodine
Y N Household Bleach
Other_____

Check if you have or ever had:

Y N Artificial limb/joint/ hip
Y N High/low blood pressure
Y N Organ transplant
Y N Sinus problems
Y N Migraines
Y N Frequent headaches
Y N Claustrophobia
Y N Artificial heart valve
Y N Prolonged bleeding
Y N Ulcers/colitis
Y N Hay fever
Y N Head injury
Y N Venereal disease/STD
Y N Mitral valve prolapse
Y N Anemia
Y N Acid reflux
Y N Arthritis/ Rheumatism
Y N Epilepsy/seizures
Y N Nervous disorders
Y N Rheumatic fever
Y N Radiation therapy/Chemo
Y N Stomach problems
Y N Glaucoma
Y N Dizziness/Fainting spells
Y N Treated for AIDS/HIV
Y N Heart murmur
Y N Thyroid problems
Y N used Phen Phen

Y N Chronic Diarrhea
Y N Stroke TIA
Y N Joint surgery
Y N Cancer/chemotherapy
Y N Blood disorder
Y N Frequent urination
Y N Bells Palsy
Y N Heart disease
Y N Diabetes
Y N Asthma
Y N Night sweats
Y N Psychiatric/emotional
Y N Recurrent infections
Y N Angina
Y N Kidney problems
Y N Excessive bleeding
Y N Addictions
Y N Pace maker
Y N Liver problems
Y N Emphysema/Bronchitis
Y N TMJ problems
Y N Respiratory problems
Y N Hepatitis A, B or C
Y N Tuberculosis
Y N Mouth ulcers
Y N Unexplained weight loss

Do You?

Y N Smoke?….. Packs per day?_____ How long?_____
Y N Chew tobacco
Y N Drink? Per week/month?_____
Y N Wear contact lenses
Y N Take diet pills?
Y N Take herbal supplements?

All information I have provided is accurate. I will update the office regarding any changes in this information. I will not hold my dentist or any member of the dental staff responsible for actions resulting from any errors or omissions that I have made in the completion of this form.

Patients are encouraged to ask all relevant dental and medical questions. Patients are to understand that dentistry is not an exact science and additional procedures and time may be required in addition to any estimates provided.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to provide you notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the notice while it is in effect. This notice takes effect on 04/14/2003 and will remain in effect until we replace it.

Signature:_____ Date: _____

For Office Use:
Comments/ considerations:

SOUTH FLORIDA SEDATION DENTISTRY
MITCHEL SENFT, D.M.D.

OFFICE FINANCIAL POLICY

In order to run our office in an efficient, effective manner, we have developed some policies for the management of our patient's financial responsibilities. Please take a few minutes to familiarize yourself with our guidelines.

APPOINTMENT POLICY

We see all patients on an appointment basis, doing our best to see all patients on time. We request that you arrive promptly for the time we have reserved for you. Upon arrival you are expected to notify us of any changes in name, address, phone or insurance information. If, for any reason, you need to make changes to your appointment, we require **48-hours notification** during business hours. In the event that we do not receive 48 hours notice or if an appointment is missed for any reason without notifying our office, we reserve the right to charge a **cancellation or no show fee of $50. For sedation appointments the fee is $199.**

PAYMENT OF FEES FOR NON-INSURED PATIENTS OR PATIENT COPAYS

Payment is due the day service is rendered in all instances, unless other arrangements have been made in advance. For your convenience, we accept cash, check, MasterCard, Visa, and Discover. We also offer no interest payment plans through CareCredit Financing.

PATIENTS WITH DENTAL INSURANCE COVERAGE

Payment of your estimated portion of your treatment is due the day service is rendered. We can attempt to find out your maximum and your deductible, but it is ultimately your responsibility to become familiar with your dental policy. Our services and our fees are based on your dental health needs and have nothing to do with your insurance company. You are ultimately responsible for the entire fee regardless of the portion covered by your insurance. We will present you with a treatment plan estimate however it is only an estimate and not a guarantee of payment by your insurance company. **If a claim is denied, downgraded, or uncollectible for any reason, any portion not paid by your insurance company will be your financial responsibility.**

Any check returned from the bank will result in an additional $35 charge that will appear on your account.

PATIENT NAME _____ DATE _____

PATIENT/GUARDIAN SIGNATURE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of South Florida Sedation Dentistry's Notice of Privacy Practices.

Signature: _____ Date: _____

For Office Use Only

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

( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please specify) _____