Welcome to Naples Dental Art Center

Chart#:

FOR OFFICE USE ONLY

Patient Name:

Last _____ First _____ MI ___ Preferred Name _____

Title: _____ (Mr/Ms/Mrs/etc) Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: _____ SS#: _____ Driver Lic. # _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ - _____ (Zip Code)

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ Phone: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Preferred Language

_____

_____

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

I confirm and attest that all information that is stated above is true and correct to my knowledge.

Signature _____ Date _____

Insurance Subscriber or Parent/Guardian Information

This only needs to be filled out if insurance subscriber is other than patient, or if patient is under 18.
The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ _____ ___ _____
Last Name First Name MI Preferred Name

Title: _____ Gender: ○ Male ○ Female Family Status: ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: _____ DL# _____

Email Address: _____ Best time to call: _____

Phone:
_____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Company Address and Phone Number:
_____
_____

Insurance Subscriber ID and Insurance Group Number:
_____
_____

Insurance Authorization:

☐ (Please check the box)
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic 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 changes whether or not paid by insurance.

I confirm that all information is true and correct.

Signature _____ Date _____

Medical History

Indicate which of the following you have had or have at present. By checking the box, it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ ADD/ADHD (circle one)
- ☐ Allergy - Latex
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Fainting
- ☐ Head Injuries
- ☐ Hepatitis A/B/C
- ☐ Kidney Disease
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Smoker
- ☐ Tuberculosis TB
- ☐ AIDS/HIV (circle one)
- ☐ Allergy - Penicillin
- ☐ Asthma
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ On Blood Thinners
- ☐ Pre-meds Needed
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Tumors
- ☐ Allergies
- ☐ Anemia
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Growths
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Mental Disorders
- ☐ Other
- ☐ Radiation Treatment
- ☐ See Medication List
- ☐ Stroke
- ☐ Ulcers
- ☐ Allergy - Codeine
- ☐ Arthritis
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Mitro Valve Prolapse
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Thyroid Problem
- ☐ Venereal Disease

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above needs further clarification, please describe below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

Name of physician and most recent physical exam:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

List all medications, supplements, and/or vitamins taken within the last two years:

_____

_____

_____

I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Signature _____ Date _____

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long have you been a patient there:

_____

_____

Date of most recent dental exam: _____

Date of most recent dental x-rays: _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had trouble getting numb
☐ Had/have braces, orthodontic treatment
☐ Had any teeth removed
☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Had your bite adjusted

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

_____

Pharmacy Name: _____ Phone # _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Signature _____ Date _____

Photo Agreement

I, hereby authorize Dr. Eetessam and staff to take radiographs of dentition and/or photographs of the head and neck areas, including the profile, face, teeth, smile, and intraoral features, pre-, during, and post-treatment of patient for the purposes of internal office use in dental records or for use in treatment planning, education, publication in professional journals, internet, and/or advertising/marketing. I understand that my identity will be blurred in most cases and that my personal information will be protected. hereby release, discharge, and agree to save harmless (Provider) and all persons acting under (his/her) permission or authority or those for whom (he/she) is acting, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether internal or otherwise, that may occur or be produced in the taking of said photograph or in any subsequent processing thereof, as well as any publication thereof, including without any limitation any claims for libel or invasion of privacy.

I have a right to restrict the use of photographic images in writing and giving it to the staff of Naples Dental Art Center.

I hereby warrant that I am of legal age and have the right o contract my own name, or I am not legal age and my parent/legal guardian whose signature is witnessed below is executing this release. I/my guardian has read the above consent prior to signing, and I/my guardian am/are fully familiar with the agreement.

By signing below, I acknowledge that I have read this statement and agree to the consents.

Signature _____ Date _____

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature _____ Date _____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1 ½% per month (18% annually) on the unpaid balance will be charged on all accounts exceeding 120 days unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I 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 I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

By signing below, I confirm that I understand the above information and agree with its contents. I also contest that I have read and understand the above conditions of treatment and payment and agree to their content.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Signature of Staff Member Date