BISCAYNE DENTAL CENTER & SPA

ARTISTRY • INTEGRITY • PASSION

WWW.BISCAYNEDENTALCENTER.COM
Tel: 305-945-7745
14550 BISCAYNE BLVD.
NORTH MIAMI, FL 33181

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

E-Mail:

HOME:
CELL:
OTHER:
PAGER:
FAX:

Referral? ☐Yes ☐No Referred by:

MEDICAL HISTORY UPDATES

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Due to an increase risk of oral Cancer demonstrated in recent studies our office requires that our patients be screened for Oral Cancer. ☐Y☐N

**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

☐Y☐N Under a physician's care now?

☐Y☐N Any hospitalization in the past 5 years?

☐Y☐N Any serious illnesses/surgeries?

☐Y☐N Use tobacco in any form? If Yes, Type:

☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐ Y☐N If yes, please describe:

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ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ACID REFLUX	☐ BULIMIA	☐ HEARING PROBLEMS	☐ PSYCHIATRIC TREATMENT
☐ ADHD	☐ CANCER/MALIGNANCY	☐ HEART ATTACK	☐ RADIATION/CHEMO
☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ HEART DISEASE	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ CHEMICAL DEPENDENCY	☐ HEART MURMUR	☐ RHEUMATIC FEVER
☐ ANOREXIA	☐ CHICKEN POX	☐ HEPATITIS	☐ SINUS PROBLEMS
☐ ANXIETY	☐ CONVULSIONS	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ ARTIFICIAL HEART VALVE	☐ DEPRESSION	☐ KIDNEY DISEASE	☐ THYROID CONDITION
☐ ARTIFICIAL JOINTS	☐ DIABETES	☐ LIVER PROBLEMS	☐ TUBERCULOSIS
☐ ARTHRITIS	☐ DIZZINESS/FAINTING	☐ MITRAL VALVE PROLAPSE	☐ ULCERS
☐ ASTHMA	☐ EPILEPSY/SEIZURES	☐ MONONUCLEOSIS	☐ VENEREAL DISEASE
☐ AUTISM/ASPERGER'S	☐ FREQUENT EAR INFECTIONS	☐ PACEMAKER	
☐ BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐ OTHER – PLEASE LIST:	

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ ASPIRIN	☐ CODEINE	☐ LACTOSE INTOLERANCE	☐ SLEEPING PILLS	☐ NONE
☐ ANESTHETIC – LOCAL	☐ DAIRY	☐ METAL SENSITIVITY	☐ SULFA DRUGS	
☐ BARBITURATES	☐ LATEX	☐ NITROUS OXIDE SEDATION	☐ PENICILLIN/OTHER ANTIBIOTICS	
☐ OTHER – PLEASE LIST				

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS	☐ ANTIHISTAMINES/ALLERGY	☐ DAILY ASPIRIN	☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS	☐ CANCER/CHEMO MEDICATIONS	☐ CORTISONE/STEROIDS	☐ HEART MEDICATION/DIGITALIS
☐ INSULIN	☐ NITROGLYCERIN	☐ ORAL CONTRACEPTIVES	☐ OSTEOPOROSIS MEDICATIONS
☐ RECREATIONAL DRUGS	☐ THYROID MEDICATIONS	☐ TRANQUILIZERS	☐ OTHERDIABETIC MEDICATIONS
☐ OTC DRUGS/ MEDICATIONS(PLEASE LIST BELOW)	☐ OTHER (PLEASE LIST BELOW)		

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature:_____ DATE:_____

RELATIONSHIP TO PATIENT: ☐ ADULT PATIENT ☐ PARENT ☐ GUARDIAN ☐ OTHER _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name: _____ **Date:**_____

RELATIONSHIP TO PATIENT: ☐SELF ☐PARENT☐GUARDIAN☐OTHER (PLEASE EXPLAIN) _____

I would like the following person(s) to have access to my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:_____

DENTAL INSURANCE

Dental Insurance Information

Policy Holder's Name: _____
Date of Birth: _____ Social Security #: _____
Employer: _____ Group #: _____
Dental Insurance ID #: _____ Dental Ins. phone#: _____
Dental Insurance Name: _____
Dental Insurance Address: _____
City: _____ State: _____ Zip: _____

Secondary Dental Insurance Information

Policy Holder's Name: _____
Date of Birth: _____ Social Security #: _____
Employer: _____ Group #: _____
Dental Insurance ID #: _____ Dental Ins. phone#: _____
Dental Insurance Name: _____
Dental Insurance Address: _____
City: _____ State: _____ Zip: _____

Person to contact in case of Emergency:

Name_____ Relationship_____Phone: _____

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INSURANCE DISCLAIMER

One of our office goals is to assist you in maximizing your dental insurance benefits. Asa courtesy to you, we will file the claim to your dental insurance carrier for servicesrendered. Note that when we call your provider, to verify benefits, it is not a guaranteeof payment by your insurance company.

Furthermore, any treatment plan that is proposed for the treatment of your dental needs/desires is an estimate of cost based on the information provided by yourinsurance carrier. It is not a guarantee of insurance coverage for services. If you wouldlike to know the exact costs for treatment, a pretreatment estimate can be submitted toyour insurance carrier. If you would like this done, you must inform our insurancecoordinator prior to initiating treatment. (This can take up to 2-6 weeks).

Please remember that the contract itemizing your dental benefits is between you, youremployer, and your insurance company. Regardless of coverage, your estimatedco-payment is due in full the day of treatment. If your insurance plan does not pay within90 days of treatment, you then become responsible for the outstanding balance forservices rendered. It is then up to you to seek reimbursement from your insurancecarrier. In the case your insurance carrier pays more than is owed for treatment, a refund will be processed. Also remember dental insurance plans are not designed tocover all your dental needs. I have reviewed this information andconsent to Biscayne Dental Center & Spa to file to my insurance claims for services rendered.

I accept full responsibility for all patient accounts that I am deemedresponsible for, personal and family. I acknowledge that it is my responsibility to beaware of the type of insurance that I am utilizing for my dental services. I alsoacknowledge that Biscayne Dental Center & Spa cannot guarantee that my insurancecarrier will cover all services rendered during my dental treatment, and that I wasprovided with an estimated cost of benefits. Finally, I acknowledge that after 90 days, Ibecome the responsible party for all costs for services rendered and that I will beresponsible for seeking reimbursement from my insurance carrier at that time.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

Written Financial Policy

Thank you for choosing Biscayne Dental Center& Spa. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:
- Cash, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options[1] from CareCredit Healthcare & Lending club
  Allow you to pay overtime
  - No annual fees or pre-payment penalties

Please note: Biscayne Dental Center & Spa requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $500 or more, a 10% deposit is required to secure your initial treatment appointment. For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice. Biscayne Dental Center charges $30 for returned checks. If you have any questions, please do not hesitate to ask.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)