

**WELCOME!**

Thank you for selecting our dental office!!!

We look forward to providing you with excellent medical cosmetics and dental specialty care.

Please help us by filling out these forms. If you have any questions please ask and

**GET ACQUAINTED QUESTIONNAIRE**

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Seasonal Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Driver's License: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Your email address: \_\_\_\_\_

Who may we thank for referring you: \_\_\_\_\_

Address: \_\_\_\_\_

Do you have Dental Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please ask the front desk for the Insurance information packet.

I understand that it is essential that this office know how to reach me and agree to update this office if I move, change phone numbers, change employers or Insurance.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_



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 Suite # 390  
 Clearwater Florida 33760  
 www.mysolutionz.com  
 Phone: 727-535-6400  
 Fax: 727-535-6848

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE**

You may refuse to sign this acknowledgment

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy for Solutionz this \_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
 Please print your name

\_\_\_\_\_  
 Please sign your name

If you are the legal representative of the patient, please print the patient's name and describe your authority:

\_\_\_\_\_

Thank you and if you have any questions about this form or the attached Notice, Please contact our Office Coordinator: Michelle McPhail

<b>OFFICE USE ONLY</b>	
As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because :	
___ It was emergency treatment.	
___ I could not communicate with the patient.	
___ The patient refused to sign.	
___ The patient was unable to sign because: _____	
Other: _____	
Signature of Privacy officer: _____	

Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person? \_\_\_\_\_

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- Yes No 1. Are you in good health? \_\_\_\_\_
- Yes No 2. Has there been any change in your general health within the past year? \_\_\_\_\_
3. My last physical examination was on \_\_\_\_\_
- Yes No 4. Are you now under the care of a physician? \_\_\_\_\_  
If so, what is the condition being treated? \_\_\_\_\_
5. The name and address of my physician (s) is \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Yes No 6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? \_\_\_\_\_  
If so, what was the illness or problem? \_\_\_\_\_
- Yes No 7. a. Are you currently taking or have you taken within the last week any prescription medicine(s),  
If so, what medicine(s) are you taking? \_\_\_\_\_
- Yes No b. Are you currently taking or have you taken within the last week any non-prescription medicine(s),  
including any antihistamines (such as Seldane) or analgesics (such as Advil, Aleve or Motrin)?  
If so, what medicine(s) are you taking? \_\_\_\_\_
- Yes No 8. Do you have or have you had any of the following diseases or problems? \_\_\_\_\_
- a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease \_\_\_\_\_
- b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) \_\_\_\_\_
- Yes No 1. Do you have chest pain upon exertion? \_\_\_\_\_
- Yes No 2. Are you ever short of breath after mild exercise or when lying down? \_\_\_\_\_
- Yes No 3. Do your ankles swell? \_\_\_\_\_
- Yes No 4. Do you have inborn heart defects? \_\_\_\_\_
- Yes No 5. Do you have a cardiac pacemaker? \_\_\_\_\_
- c. Allergy or hay fever? \_\_\_\_\_
- Yes No d. Sinus trouble? \_\_\_\_\_
- Yes No e. Asthma or hay fever? \_\_\_\_\_
- Yes No f. Fainting spells or seizures? \_\_\_\_\_
- Yes No g. Persistent diarrhea or recent weight loss? \_\_\_\_\_
- Yes No h. Diabetes? \_\_\_\_\_
- Yes No i. Hepatitis, jaundice or liver disease? \_\_\_\_\_
- Yes No j. AIDS or HIV infection? \_\_\_\_\_
- Yes No k. Thyroid problems? \_\_\_\_\_
- Yes No l. Respiratory problems, emphysema, bronchitis, etc.? \_\_\_\_\_
- Yes No m. Arthritis? \_\_\_\_\_
- Yes No n. Stomach ulcer or hyperactivity? \_\_\_\_\_
- Yes No o. Kidney trouble? \_\_\_\_\_
- Yes No p. Tuberculosis? \_\_\_\_\_
- Yes No q. Persistent cough or cough that produces blood? \_\_\_\_\_
- Yes No r. Persistent swollen glands in neck? \_\_\_\_\_
- Yes No s. Anorexia or bulimia? \_\_\_\_\_



*Patient Cosmetic Questionnaire*

Yes  No Do you see any "saggy skin" when you look at your face or body that you would want addressed?

Yes  No Do you wish that you could remove any unsightly age spots or correct sun damaged spots?

Yes  No Do you wish for results that will deliver immediate skin tightening of your face or other body parts?

Yes  No Do you notice any wrinkles or scars that concern you with your appearance?

Yes  No Do you see any discoloration or vascular lesions that concern you and you would like them address?

Yes  No Do you notice any unsightly veins, spider veins, or leg veins that concern you?

If you have any other concerns or questions that you would like the Doctor to address, that is not list above, please write those below to assure you receive all information needed for your customized treatment!....

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**Dental Self Analysis Questionnaire**

*Why change your smile? If you are happy with your smile, great! But please ask your self the following questions: \_*

Yes  No When you look at your smile, do you notice any defects in your gums or teeth that you would like address by the Doctor?

Yes  No Does your self –confidence lessens when smiling in front of others?

Yes  No Do you wish you could make your teeth whiter?

Yes  No Do you wish your teeth were shaped differently than they are now?

Yes  No Would you be interested in a full cosmetic dental make-over to improve your appearance and self-confidence?

If you have any other concerns or questions that you would like the Doctor to address, that is not listed above, please write those concerns below to assure you receive all information needed for your customized treatment!.....

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Insurance Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ID/SS # \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

**OFFICE USE**  
**INSURANCE BREAKDOWN**

Group number: \_\_\_\_\_ effective date: \_\_\_\_\_

Maximum: \_\_\_\_\_ Deductible: \_\_\_\_\_ calendar / fiscal yr

Preventative: \_\_\_\_\_ % Pano/fmx: \_\_\_\_\_

Bitewings: \_\_\_\_\_

Exams/OV: \_\_\_\_\_

Prophy: \_\_\_\_\_

Basic: \_\_\_\_\_ % Perio: \_\_\_\_\_

Endo: \_\_\_\_\_

Oral Surgery: \_\_\_\_\_

Major: \_\_\_\_\_ % Crwns & Brdgs: \_\_\_\_\_

Partls & Dntrs: \_\_\_\_\_

Ortho: \_\_\_\_\_ % (1/4 - 1/2) Max: \_\_\_\_\_ Ded: \_\_\_\_\_

Age Limit: \_\_\_\_\_

Missing th: yes/no Replacement: \_\_\_\_\_ yrs Waiting Period: \_\_\_\_\_

# Implant & General Dentistry of Tampa Bay, P.A.

Hani S. Tadros, D.D.S.

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## INSURANCE GUARANTEE OF PAYMENT

### Terms and Condition

Patient Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

It is a policy in our office to file your insurance as a COURTESY to our patients.

I hereby authorize the release of information to my insurance company. I authorize if necessary, the dentist/office to request a review of, and or pursue an appeal with my insurance company claim determination.

I also understand that my insurance company does not cover cosmetic procedures or procedures covered by alternate treatment benefits (i.e. Partials vs. bridges, amalgam vs. composites (white) fillings, etc). I will be responsible in price over and above the insurance payment. I have agreed with my dentist the optimal treatment is preferred.

After 30 days from filing your Insurance claim and NO payment has been received, **you will be responsible** for those charges assessed to your account. As you know Insurance companies DO NOT guarantee payment on either written or verbal verification. That is why we require a credit card number to be on file with our office. **Please be ASSURED that the front desk staff will inform you before your credit card is processed for payment on any outstanding balance.** If you do not understand this policy or need to ask a question regarding this matter please feel free to speak with our Insurance Coordinator before any treatment is completed.

I hereby authorize Implant General Cosmetic Dentistry to charge my credit card with my verbal and written consent. By signing, I agree that charges can not be disputed and that I am fully aware of the terms and conditions stated above.

Lab fees (\$200.00 per unit) are billed separately.

\_\_\_\_\_  
Authorize Signature    date

\_\_\_\_\_  
Credit Card number

\_\_\_\_\_  
Expiration date / VOS#

\_\_\_\_\_  
Cardholder's Name

\_\_\_\_\_  
Cardholder's address

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If you DO NOT wish to have your credit card number on file, you will then be required to pay in full at time services are render and your insurance company will reimburse you directly.

\_\_\_\_\_  
I assume full responsibility for payment.