

New Patient Information

Patient's Name: _____
Soc. Sec.# _____
Age: _____ Gender: _____ D.O.B: _____
Address: _____ City: _____
State: _____ Zip code: _____

Home phone: _____ Work# _____
Cellphone: _____
School: _____ Grade: _____

Referred by: _____
Email Address: _____

Insurance Information:

Do you have Dental Insurance? Yes___ or No___ (if so, please ask the front desk for the insurance information packet).

Current Dental Information:

Patient's Dentist: _____
Dentist Address: _____
Phone#: _____
Patient's last dental cleaning and check-up with your Dentist:



15950 Bay Vista Dr.
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

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

| |
|-----------------|
| Medical History |
|-----------------|

Do you have or have you had any of the following medical problems?

| YES | or | No | YES | or | NO |
|-----------------------|----|-------|--------------------------|----|-------|
| Diabetes _____ | or | _____ | Tuberculosis _____ | or | _____ |
| Anemia _____ | or | _____ | Epliespy _____ | or | _____ |
| Pneumonia _____ | or | _____ | Asthma _____ | or | _____ |
| Rheumatic Fever _____ | or | _____ | Kidney Involvement _____ | or | _____ |
| Bone Disorders _____ | or | _____ | Prolonged Bleeding _____ | or | _____ |
| Heart Trouble _____ | or | _____ | Liver Involvement _____ | or | _____ |
| Fainting/Dizzy _____ | or | _____ | Nervous Disorders _____ | or | _____ |
| HIV(Aids virus) _____ | or | _____ | Latex Allergy _____ | or | _____ |

Do you require pre- medication before dental appointment? _____

Are you in good health? _____

Are you under the care of physician(if yes, why?) _____

List any medications you are currently taking: _____

List any other medical conditions that you know of: _____

List any allergies or drug sentitives: _____

| | | | | |
|--------------------------------------|-------|----|-------|--|
| Has the patient reached puberty? | YES | or | NO | |
| Girls, have you started menstruation | _____ | | _____ | |
| Boys, has your voice changed | _____ | | _____ | |

Signature _____

Date: _____

(Parent or guardian if patient is minor)

***** Office Use Only *****

Exam Date: _____

Molars R____ L____

OB____ OJ____

Primary dentition:

Cuspids R____ L____

Midline Mx____ Md____

Upper Crowding/Spacing _____mm

Lower Crowding/Spacing _____mm

Profile _____

Oral Hygiene _____

Lip posture _____

Caries _____

Chin-throat depth _____

Perio _____

Labiomental fold _____

Eruption Concerns _____

Frenum _____

Habits _____

Other: _____

TMJ

Click R or L

Max Opening _____mm

Pain R or L

CR=CO _____

Trauma R or L

Recommend TX:

Bracket type/ Direct or Ind

Est. TX time:

Spacers/Bands

Extractions, expander or SX:

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!.....

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.

Michael Brumm, D.M.D.

Lauris Wallace, D.M.D.

15950 Bay Vista Drive, Suite 390

Clearwater, FL 33760

727-535-6400 phone 727-535-6848 fax

www.mysolutionz.com

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

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.

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!....
