Welcome to our practice! We at Parker Dentistry would like to thank you for selecting our practice to provide your dental needs. We recognize the trust and responsibility placed on us and we intend to live up to your expectations. Our practice takes pride in being prevention oriented but also recognize the need for prompt emergency care should the need arise.

We want you to feel relaxed and comfortable with us and know that our concern is taking care of your dental needs. We would enjoy visiting with you regarding any questions you may have about your dental care or our office policies. If there is anything we can do to make you more comfortable with the services we provide, please do not hesitate to let us know.

For your convenience we accept Visa, MasterCard, Discover, American Express, Cash and personal checks. Payment is due at the time of your dental visit.

Our appointments are scheduled to respect your time. We reserve a specific time for your care and make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change an appointment, a 48-hour notice is appreciated.

Thank you again for selecting our practice and we look forward to seeing you on,

________________________ at ___________________.

Sincerely,

The Doctors and Staff

Parker Dentistry
954-983-5450

PATIENT INFORMATION

Date:________/_________/________ Date of Birth: _______/_______/_______

Patient Name: Nickname:________________________

Address:___________________________________ Social Security # _______/____/______

____ Home # ________________________

City State Zip Cell #___________________________

Employer:______________________________ Wk # __________________________

Employer Address: _______________________ Other#___________________________

____ Email____________________________

City State Zip Occupation: ______________________

***Spouse/Parent (if dependant name of responsible* party**)

Name: _________________________________ Social Security # ______/____/_______

Address_______________________________ Date of Birth: ________/_____/_______

______________________________________ Home # __________________________

City State Zip Occupation: _______________________

Employer: ______________________________ Wk # ____________________________

Employer Address ______________________ Cell # ____________________________

______________________________________ Email: ____________________________

City State Zip

Insurance Information (For Patients with dental insurance)

***Primar*y** Employee Name: ____________________ Employee Date of Birth ____/_____/_____

Employer: ____________________________# years employed__ Policy # :_________________

Name of Insurance Co. _________________________ Social Security #_____/_____/_______

Group Number:___________ Insured's Address if different from above ___________________

Secondary Employee Name: _____________________ Employee Date of Birth _____/___/___

Employer: ___________________________# years employed___ Policy # :__________________

Name of Insurance Co. _________________________ Social Security number____/___/_____

Group Number:__________ Insured's address if different from above_______________________

Person to contact in case of emergency: _______________________________Phone: ____________

Relationship: ___________________________________Address: ____________________________

Whom may we thank for referring you to our office? _______________________________________

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Notice of Privacy Practices

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment):
- Obtaining payment from third party payers (e.g. insurance company):
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice *of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this __________day of ______________200_____

Print Patient Name: ______________________________

Relationship to Patient: ___________________________

Signature: ______________________________________

Parker Dentistry
954-983-5450

Name:

Medical History

Do you have a personal physician?
0 Yes 0 No
Physician's Name ________________________
Phone # _____/_____/______
Date of last visit : _____/____/_______
Current Physical health is
0 Good 0 Fair 0 Poor
Are you under current care? 0 Yes 0 No
Please explain: _____________________
Do you smoke or use tobacco in any form?
0 Yes 0 No
Are you taking any prescriptions/over the counter drugs? 0 Yes 0 No
Please list each one: ________________

For women: Are you taking birth control pills?
0 Yes 0 No
Are you Pregnant? 0 Yes 0 No Week? ____
Are you nursing? 0 Yes 0 No

Have you ever had any of the following?

Y N Anemia/Radiation Treatment
Y N Heart Surgery/Pacemaker
Y N Artificial Bones/Joints
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes/Tuberculosis (TB)
Y N Difficult Breathing
Y N Drug / Alcohol Abuse
Y N Emphysema / Glaucoma
Y N Epilepsy / Seizures / Fainting Spells
Y N Fever Blisters / Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Hemophilia / Abnormal Bleeding
Y N Hepatitis
Y N High / Low Blood Pressure
Y N Hiv +AIDS
Y N Hospitalized for Any Reason
Y N Kidney problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers / Colitis
Y N Venereal Disease

Any Other Medical Information?

Please List any serious medical conditions that you may have ever had:

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin
Y N Codeine Y N Latex
Y N Penicillin Y N Dental Anesthetics
Y N Tetracycline Y N Other
Please List any other drugs Allergies:

Dental History

Why have you come to the dentist today?___________________________________
Are you currently in pain? Y N
Have you ever had a serious / difficult problem associated with any previous dental work? Y N
Have you ever had gum treatment? Y N
Do you now or have you ever experienced Pain, discomfort in your jaw joint (TMJ/TMD)? Y N
Your current dental health is:
0 Good 0 Fair 0 Poor
Do you like your smile? Y N
Do your gums bleed Y N
How many times a week do you floss? ____
How many times a day do you brush? _____
Type of bristles? 0 Hard 0 Medium 0 Soft
How long do you use a toothbrush before replacing it?
____
Are your teeth sensitive to heat, cold or anything else?
____
Have you lost any teeth? Y N
If yes why? _____________________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status

X_______________________________________
Signature Date

Office Use Only: I verbally reviewed the medical / dental information above with the patient named herein.

Doctor's Signature *Date*

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Financial Policy

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any com0payment, deductibles or fees that my insurance does not cover.
In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt

It is in your best interest to know exactly what services are provided by your insurance plan. We care for patients who represent many different company plans and each plan is slightly different in its covered services. You may want to verify your benefits.

If you have a co-pay or deductible, payment will be required at the time of your visit. If your deductible has been met, please provide us with evidence of this. The remainder of your covered services will be submitted to your insurance company and our office will accept assignment. Please sign the "assignment of benefits" below to allow us to file your insurance claims. You will be responsible for any non-covered services, and will be asked to pay for these at the time of your visit.

We are happy to submit your insurance for you and accept assignment of benefits as a courtesy. We do not have any contracts with insurance companies. Our only contract is with you. Any balance unpaid by the insurance company after 60 days becomes the responsibility of the patient and we ask that it be paid at that time. We will continue to assist you in obtaining reimbursement from your insurance carrier. We submit insurance daily and resubmit if payment has not been received within 30 days and again in 60 days with a letter to the insurance commissioner.

We will need to copy the front and back of your insurance card upon arrival.

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment the doctor and or his staff will give a full explanation of the procedure(s) involved. I agree to pay for all services rendered by this office. If any payment is not made and considered in default, then patient or responsible party is responsible for any and all collections attorney's fees. There will be a $25.00 charge for any returned check due to insufficient funds. I understand interest of 18% per annum (1.5% monthly) may be charged on account over 30 days delinquent. I further understand and give permission to access my credit for the intent of extending payments.

I hereby authorize Dr. _____________ to release to my insurance company, information
Acquired in the course of my dental care. I hereby authorize benefits to be paid directly to
Dr.________________________. I understand I am responsible for any unpaid balance.

X ____Date_____________
Signature of Patient/Insured

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