PARADISE DENTAL

Patient Information

Patient Name: _____ (_____) **Title**: ○ Dr. ○ Miss ○ Mr. ○ Mrs. ○ Ms.
Last, First MI Preferred Name/Nickname

Gender: ○ Male ○ Female **Marital Status**: ○ Married ○ Single ○ Child **Birthdate**: _____ **SS#**: _____

Address: _____
Address

_____
City **State** **Zip Code**

Email: _____ **Home Phone**: _____

Work: _____ **Ext**: _____ **Cell**: _____ **Best number to reach you?** ○ Home ○ Work ○ Cell

Would you like appointment reminders sent via e-mail? Yes ▼ **Would you like appointment reminders sent via text?** Yes ▼

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergic to Anesthetic
- ☐ Allergic to Codeine
- ☐ Allergic to Penicillin
- ☐ Allergic to Latex
- ☐ Allergic to Sulfa
- ☐ Allergic to _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Problems: _____
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnant Due: _____**
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus/Allergy Issues
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Herbal Supplements

Other Conditions

- ☐ _____
- ☐ _____
- ☐ **Dental Fear**

Please list all medications you are presently taking:

_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of Patient, Parent or Guardian

_____ Date: _____
Signature of Dentist

PARADISE DENTAL

Referral Information

Whom may we thank for referring you to our practice?

- ☐ Sarasota Yellow Pages
- ☐ Bradenton Yellow Pages
- ☐ Another patient, Name: _____
- ☐ Newspaper
- ☐ School
- ☐ Specialist, Name: _____
- ☐ Work
- ☐ Location
- ☐ Other: _____

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street, City State Zip Code Phone

Spouse or Guardian/Parent Information

The following is for: ☐ the patient's spouse ☐ the guardian/parent

Name: _____ (If Guardian/Parent: Gender: _____ Marital Status: _____)

Is this person a patient? ☐ Yes ☐ No

Complete the following if different from Patient's information

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street

_____
City State Zip Code

Insurance Information (Dental Only)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ SS# _____ ID #: _____

Insured's Address: _____
Street, City State Zip Code

Insured's Employer: _____ Emp. Address: _____

Insurance Company: _____ Phone: _____ Group #: _____

Address: _____
Street, City State Zip Code

(Please provide card)

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of adult patient or parent/guardian

Relationship To Patient ☐ Self ☐ Parent ☐ Guardian
Other: _____

Privacy Notice and Consent

Paradise Dental Health Professionals believe our patients have the right to privacy and that their personal financial and health information should be kept confidential. New laws now require that we notify you about our privacy policy in writing.

How do we use your personal information?

***We will use your personal health information to provide, coordinate, or manage your dental **treatment** and any related services. This may include providing necessary information to pharmacy personnel, laboratory technicians, or to third party health care providers such as a specialist. Personal information may be given to your insurance company if necessary to facilitate **payment** of your claims.

On occasion your personal information may be used for in supporting the practice's business operations. These activities include, but are not limited to, quality assessment activities, employee reviews activities, training of dental students, licensing, and conducting or arranging for other business activities. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may also use or disclose your personal information in the following situations without your authorization as required by law: Public health issues/communicable diseases, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners request, research, criminal activity, national security, workers compensation.

Other permitted and required uses and disclosures will be made only with your consent, authorization and opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

What are your rights?

- You have the right to inspect and copy your personal information
- You have the right to request a restriction of your personal information. This means you may ask us not to use or disclose any of your personal information for the purposes of treatment, payment, or operations. You may also request that any part of your information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested, in writing, and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit the use and disclosure of such information, it will not be restricted. You then have the right to use another healthcare professional.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
- You may have the right to have your dentist amend your personal health information
- You have the right to receive an accounting of certain disclosures we have made, if any, of your personal health information

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You can be assured there will be no ill-will following a complaint by you.

Acknowledgement of Receipt of Notice of Privacy Practices

This is to verify that I have read and understand the above information. By signing this statement, I am giving Paradise Dental Health Professionals and its team member's permission to release my personal information as described above.

Signature_____ **Date**_____

You May Refuse to Sign This Acknowledgement *This notice was published and becomes effective on/or before 4/14/2003.*

******By refusing to sign this form, you will be responsible for services described above, which are usually addressed by your dental provider.***

PARADISE DENTAL

JEFFREY MARTINS, D.D.S.
Cosmetic and Restorative Dentistry

Release of Information

Patient's Name_____

Patient's date of birth_____

I, the patient, give the right for my records to be shared with:

Name(s):_____

_____

I give full consent for all my records at Paradise Dental to be discussed and I understand that I must notify Paradise Dental if I wish to make any changes in the future.

_____
Patient's Signature

_____
Date

P (941) 744-1226 • F (941) 744-2967
1711 Lakewood Ranch Blvd. • Lakewood Ranch, FL 34211
Email: hello@paradisedentalsmiles.com
Website: www.paradisedentalsmiles.com