Date: _____

Office Use Only
*Chart #:*_____

WELCOME!

Please provide your license, dental and medical insurance cards for our records. (We do not accept Medicare.)

Patient Information

Patient Name: _____
Last, First MI (Preferred Name)

Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Date of Birth: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

E-Mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

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

Do you have dental Insurance? ☐ Yes ☐ No Name of Insurance: _____

Do you have medical Insurance? ☐ Yes ☐ No Name of Insurance: _____

Employer Name: _____ Occupation: _____

Address: _____
Street Suite #

_____
City State Zip Code

Spouse or Responsible Party Information

(only fill out if different than patient)

Patient's relationship to responsible party: ☐ Spouse ☐ Child ☐ Other _____

Name: _____
Last, First MI (Preferred Name)

Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Date of Birth: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

E-Mail: _____

Address: _____
Street Apartment # City, State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street Apartment # City, State Zip Code

DENTAL HISTORY

What is your primary reason for this dental appointment? _____

_____

How often do you brush? _____ Floss? _____

When was your last dental cleaning? _____

How often do you get your teeth cleaned? _____

When were your last x-rays? _____

Name of Previous Dentist: _____ Phone: _____

Do you see a periodontist? ☐ Yes ☐ No

Name of Periodontist: _____ Phone: _____

Does food catch between your teeth? Where? _____ ☐ Yes ☐ No

Do your gums ever bleed? When? _____ ☐ Yes ☐ No

Do you suffer from dry mouth? _____ ☐ Yes ☐ No

Do you ever have popping, clicking, or discomfort in your jaw joint? _____ ☐ Yes ☐ No

Do you clench or grind? When? _____ ☐ Yes ☐ No

Do you smoke? How much? _____ ☐ Yes ☐ No

Do you chew? How much? _____ ☐ Yes ☐ No

E-Cigarette? How much? _____ ☐ Yes ☐ No

Do you snore? _____ ☐ Yes ☐ No

Do you stop breathing when asleep? _____ ☐ Yes ☐ No

Do you wake up exhausted in the morning? _____ ☐ Yes ☐ No

Do you wear a C-PAP? _____ ☐ Yes ☐ No

Health Information

☐ Acid Reflux	☐ Cancer	☐ Heart Murmur	☐ Psychiatric Care
☐ AIDS	☐ Chest Pain	☐ Hepatitis _____	☐ Radiation Treatment
☐ Allergies	☐ Diabetes Type: _____	☐ High Blood Pressure	☐ Respiratory Problems
☐ Codeine Allergy	☐ Dizziness	☐ Insomnia	☐ Rheumatic Fever
☐ Penicillin Allergy	☐ Emphysema	☐ Impaired Cognition	☐ Rheumatism
☐ Lidocaine Allergy	☐ Epilepsy	☐ Jaundice	☐ Stomach Problems
☐ Latex Allergy	☐ Excessive Bleeding	☐ Kidney Disease	☐ Stroke
☐ _____	☐ Fainting	☐ Liver Disease	☐ Substance Abuse
☐ Anemia	☐ Gastritis/Gerd	☐ Mental Disorder	☐ Thyroid Problems
☐ Arthritis	☐ Glaucoma	☐ Mood Disorder	☐ Tumors
☐ Asthma	☐ Head Injuries	☐ Pacemaker	☐ Tuberculosis
☐ Atrial Fibrillation	☐ Heart Attack	☐ Pregnancy	☐ Ulcers
☐ Auto Immune Disease	☐ Heart Disease	Due Date: _____	☐ Other: _____
☐ Blood Disease			

- Do you have any artificial joints? ☐ Yes ☐ No

  If yes, please list where and when surgery was completed: _____

- Do you need to pre-medicate prior to your dental visits? ☐ Yes ☐ No

  If yes, please list the name and dosage: _____

MEDICAL HISTORY

Name of Physician: _____ Phone: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, explain: _____

Are you now under the care of a physician? _____ ☐ Yes ☐ No

If yes, explain: _____

Have you ever had oral sedation? _____ ☐ Yes ☐ No

Have you ever had IV sedation? _____ ☐ Yes ☐ No

When was the last time you were sedated? _____ ☐ Yes ☐ No

Have you ever had a bad reaction to local, oral, or IV sedation? _____ ☐ Yes ☐ No

Are you on a blood thinner? _____ ☐ Yes ☐ No

☐ Brillinta ☐ Eliquis ☐ Plavix ☐ Pradaxa ☐ Warfarin ☐ Xarelto ☐ Other: _____

Do you have osteoporosis? _____ ☐ Yes ☐ No

Are you currently taking, or have you taken any of the following in the last 10 years?

☐ Actonel ☐ Boniva ☐ Fosomax ☐ Prolia ☐ Zometa ☐ Other _____

Please list any other medications you are currently taking: *(or give us a copy of your list for our records)*

MEDICATION	DOSAGE	FREQUENCY

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.

X _____ _____

Signature of patient, parent or guardian — Date

_____ _____

Print name — Relationship to patient

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. The following is information regarding our insurance and financial policies.

Consent for Services and Financial Policy

Fee For Service

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. Our office practices a fee for service model. Payment is due at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Insurance

Insurance is a contract between the insurer and the patient. It is the patient's responsibility to know and understand the terms, guidelines and limitations of the plan. It is also the patient's responsibility to advise us of any changes in their insurance, their address, or their employer.

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 and submit the patient's insurance forms as a courtesy. Reimbursement will be mailed to the patient from his or her insurance carrier. However, this dental office will not render services on the assumption that our charges will be paid by an insurance company.

Assignment of Benefits

I understand that payment is due at the time of service. If in the event non-payment occurs, I agree to assign all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. The assignment of benefits allows the office of Garrett S. Dennis, D.M.D. to be paid directly by my insurance carrier or other benefit plan for the services Garrett S. Dennis, D.M.D. and his team provides me, my minor child, or other person(s) entitled to healthcare benefits for this admission.

Medicaid

We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

Treatment Proposals

I understand that the fee estimate listed for this dental care can only be extended for a period of twelve months from the date of the patient examination. The direction of treatment can change when the doctor is performing services based on his findings, at which time we will communicate with the patient any differentiation in the treatment plan.

Minors

A parent or legal guardian must authorize treatment and financial arrangements for all patients under the age of 18.

Missed appointments

Missed appointments represent a cost to us and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hrs. in advance of the scheduled appointment. If it becomes a frequent issue, we reserve the right to asses a fee.

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. 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 or e-mail me to discuss matters related to this form.

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

X _____ _____

Signature of patient, parent or guardian — Date

_____ _____

Print name — Relationship to patient

HIPAA COMPLIANCE

Acknowledgement of Receipt of Notice of Privacy Practice

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of our office Notice of Privacy Practice.

This notice is available in hard copy by verbally requesting a copy at the front desk or by calling (239)598-4333, or by submitting a request in writing to our HIPAA Privacy Officer at 2388 Immokalee Rd. Naples, FL 34110.

Consent to Release of Information.

I authorize Garrett S. Dennis, D.M.D. and his team to release my medical information and supporting documents of same, as compiled in my record during this visit, in accordance with HIPAA law unless otherwise prohibited by the completion of a "PHI Special Restriction Request" form by the patient or patient's representative. I acknowledge that data from my record will be accessible to all healthcare providers participating in my healthcare treatment including, but not limited to, Garrett S. Dennis, D.M.D. his team, and/or dentist(s)/physician(s) to whom I am referred for further treatment.

I also acknowledge that my medical record will be made available to government agencies as required by law. I authorize Garrett S. Dennis, D.M.D. and his team to request pertinent dental/medical information and supporting documents from any healthcare providers participating in my healthcare treatment.

Consent to Receive Communication

If at any time I, or a person I am responsible for, provides contact information (a wireless or landline telephone number, address, email) at which I may be contacted, I consent to receive communication in any manner, including but not limited to; automated emails, voice mails, written statements, texts, autodialed calls and pre-recorded messages, which could result in charges to me. This healthcare provider may pass this right on to its successors and assigns, other medical providers used during the course of treatment, affiliates, agents, and independent contractors, including, but not limited to, servicers and collection agents. This contact information may be used for treatment, payment, and operations.

I acknowledge that I am an authorized user of this contact information and that I have permission to use said contact information from the actual current subscriber of the information. It is my responsibility to update this healthcare provider with new and updated contact information and that, if I fail to update this information, I will hold the healthcare provider harmless for untimely notifications.

I certify that I have read and understand the contents of this form.

X _____ _____

Signature of patient, parent or guardian — Date

_____ _____

Print name — Relationship to patient

HIPAA COMPLIANCE

Protected Health Information (PHI) Disclosure Authorization

Representatives of Dr. Garrett Dennis's office may leave detailed messages at the following telephone number(s):

Phone #: _____ Phone #: _____

Emergency Contact Name: _____ Phone: _____

Patient E-mail Address: _____

By providing your e-mail address, you agree to receive email notices from us, including notifications regarding your patient account. *Emailed records sent to an unencrypted email address may be viewable by an unauthorized party. By selecting this delivery method you understand and accept the inherent risks of receiving records via email to the address you specify.

The office of Garrett S. Dennis, D.M.D. may release any information (copies of exams, test results, appointment times & dates, medical & financial information) to the person(s) you list below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that a copy of the Notice of Privacy Practices is available for my review at any time. This notice is available in hard copy by verbally requesting a copy at the front desk or by calling (239)598-4333, or by submitting a request in writing to our HIPAA Privacy Officer at 2388 Immokalee Rd. Naples, FL 34110.

I understand that the office of Garrett S. Dennis, D.M.D. may use or disclose my protected health information (PHI) for the purposes of medical treatment, payment, and healthcare operations. The office of Garrett S. Dennis, D.M.D. also share information in the following circumstances: • During a medical emergency, if the restricted information is needed to provide emergency care • For reporting abuse, neglect, domestic violence or other crimes • For health oversight activities, law enforcement investigations, judicial or administrative proceedings • For identifying decedents to the coroner, or determining cause of death • For worker's compensation programs • For uses or disclosures otherwise required by law • For the Business Associates (BA) performing services on behalf of the office of Garrett S. Dennis, D.M.D. as noted in the Notice of Privacy Practices.

I understand that I can revoke this authorization at any time by written request. I understand that the office of Garrett S. Dennis, D.M.D. may not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to applicable privacy laws.

I certify that I have read and understand the contents of this form.

X _____ _____

Signature of patient, parent or guardian — Date

_____ _____

Print name — Relationship to patient