Entered by: _____

Patient Information

Last Name_____ First_____ Middle_____

Street Address_____ City _____ State_____ Zip _____

Home Phone_____ Cell Phone_____ Work _____

Date of Birth_____ Sex: M or F Social Security Number _____

Occupation _____ Employer _____

Drivers License Number _____ State _____

Marital Status: Single Married Divorced Widowed Minor

Email Address_____ Can you receive texts on cell number? Y or N

Fill this section out if patient is a minor.
Billing Information: Information of the person bringing child to the appointment.

Parent or Guardian Name_____ Relationship _____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____

Date of Birth _____ Social Security Number _____

Insurance Information: Policy Holder

Primary

Policy Holders Name_____ Relationship to Patient_____

Date of Birth_____ Social Security Number_____ Sex M or F

Insurance Company Name_____ Phone Number _____

Employer_____ ID Number _____ Group Number _____

Secondary

Policy Holders Name_____ Relationship to Patient_____

Date of Birth_____ Social Security Number_____ Sex M or F

Insurance Company Name_____ Phone Number _____

Employer_____ ID Number _____ Group Number _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO AND HERBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO ORLANDO LIFESTYLE DENTURES & IMPLANTS FROM MY INSURANCE COMPANY.

Signature _____ Signature of Insured _____

Who may we contact in case of emergency? _____( )_____

Physician's Name and Phone Number _____ ( )_____

HOW DID YOU HEAR ABOUT ORLANDO LIFESTYLE IMPLANT DENTISTRY?

____ Referred by a patient. Name _____	____ Television What Channel_____
____ Referred by an employee. Name _____	____ Radio What Station _____
____ Direct Mail. What type _____	____ Internet
____ Brochure	____ Yellow Pages
____ Newspaper	____ Other _____

Patient Medical History

Patient Name_____ Date of Birth_____

Today's Date _____ Sex: M or F Height _____ Weight _____

Please provide the name, address, and phone number of your primary care doctor.

Name_____ Phone Number _____

Address_____ City_____ State_____ Zip_____

For the following questions, please circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health?	Y or N
Have there been any changes in your health in the last year?	Y or N
Have you had a physical examination in the last year? If yes, Date _____	Y or N
Are you currently under the care of a physician?	Y or N
if so, what is your condition being treated?_____	Y or N
Have you had any serious illness, operation or hospitalization with in the last 5 yrs?	Y or N
Are you currently taking any medications including over the counter or vitamins?	Y or N

if so please list: _____

_____

_____

_____

Do you have or have you had any of the following diseases or health problems?

a)Damaged heart valves, artificial valves or heart murmur?	Y or N
b)Rheumatic Heart Disease	Y or N
c)Heart trouble, heart attack, angina, high blood pressure, stroke,	Y or N
arteriosclerosis or any other heart condition _____	Y or N
1) Do you experience chest pain upon exertion?	Y or N
2) Do you experience shortness of breath after mild exercise?	Y or N
3) Do your ankles swell?	Y or N
d) Do you have any allergies other than medications? If so please list_____	Y or N

_____

_____

e) Sinus trouble	Y or N
f) Asthma or Hay Fever	Y or N
g) Fainting, Dizzy Spells or Seizures	Y or N
h) Diabetes	Y or N
I) Hepatitis, jaundice, or liver disease	Y or N
j) Frequent or recurring mouth sores	Y or N
k) Thyroid problems	Y or N
l) Respiratory problems, emphysema, bronchitis, etc	Y or N
m)Arthritis or painful, swollen joints, including jaw joint (TMJ)	Y or N
n)Stomach Ulcers	Y or N
o)Hyperactivity	Y or N
p)Kidney trouble	Y or N
q)Tuberculosis	Y or N
r) Persistent Cough or cough that produces blood	Y or N

s) Persistent swollen neck glands	Y or N
t) Low blood pressure	Y or N
u)Do you currently have, or have you ever had Cancer or Leukemia?	Y or N
if so, when _____ what type_____	
Name of treating physician _____	Y or N
w) Any disease, drug or transplant operation that has depressed your	
immune system?	Y or N
Do you have abnormal bleeding?	Y or N
a) Have you ever had a blood transfusion?	Y or N
Do you have a blood disorder, such as anemia?	Y or N
Have you ever had treatment for a tumor or growth?	Y or N
Are you allergic to or have you had any type of reaction to:	
a) Local anesthesia	Y or N
b) Penicillin or other antibiotics Please list _____	Y or N
c) Sulfa Drugs	Y or N
d) Barbiturates or sleeping pills	Y or N
e) Aspirin	Y or N
f) Iodine	Y or N
g) Codeine or any other narcotics	Y or N
h) Latex	Y or N
i) Other please list _____	Y or N
Are you now taking any bisphosonates, sometimes known by the brand names:	
a) Aredia b) Actonel c) Boniva d) Didronel e) Fosomax f) Reclast g) Seklid h) Zometa	Y or N
Please list name of prescribing physician _____	
Do you have or have you ever been treated for osteoporosis?	Y or N
if yes when?_____ Name of physician_____	
Have you ever been diagnosed with Padget's disease of the bone?	Y or N
if yes when?_____ Name of physician_____	
Have you had any serious trouble with dental treatment before?	Y or N
if yes when?_____	
Have you ever been advised to take antibiotics prior to dental treatment?	Y or N
if yes when and by whom?_____	
Do you have any other condition or disease not listed above that you feel your	Y or N
dentist would need to know? If yes, please explain _____	
_____	
_____	
Are you wearing contact lenses?	Y or N
Are you wearing and removable dental appliances?	Y or N
Do you wish to speak with the dentist privately about any matter?	Y or N
This section pertains to women only	
Are you pregnant or trying to get pregnant?	Y or N
Do you have problems associated with your menstrual cycle?	Y or N
Are you nursing?	Y or N
Are you currently taking birth control?	Y or N

What is your chief dental complaint? _____

_____

_____

Please list current medications (or attach a list) _____

_____

_____

_____

_____

Certification

I certify that I have read and completed the information requested on the patient medical history for to the best of my knowledge. I acknowledge that my care and treatment will be provided based on my health and dental status as I have indicated on my medical history form. I further certify that I have had an opportunity to ask any questions that I have had and they were answered to my satisfaction. I also certify that by signing this document, I agree not to hold my dentist and any member of the dental staff harmless for any errors or omissions that I have made in the completion of this form, or for any information requested of me that I did not provide verbally or In writing to my dentist that may impact the out come of my dental care and treatment.

Print Name:_____

Signature: _____ Date: _____

TO BE COMPLETED BY THE DOCTOR:

Comments:_____

_____

_____

Significant findings from questionnaire or oral interview:_____

_____

_____

Dental management considerations:_____

_____

_____

Does patient need a medical clearance prior to treatment: Y or N

Does the patient require pre-med before treatment: Y or N

Is patient taking blood thinners: Y or N

Date: _____ Doctor's Signature_____

Payment Policy

Thank you for choosing Orlando Lifestyle Implant Dentistry as your dental care provider. We are committed to providing you with quality and affordable dental care. If you help us keep our overhead and collections cost down, we can keep providing you with affordable dentistry. Below you will find our payment policy. **Please read and initial in the designated area and then sign and print your name at the bottom of the page.**

Insurance

We accept all **PPO Dental Insurance Policies** and are **In Network** with **Delta Dental** and **United Concordia ONLY.** We **DO NOT** accept DMO or HMO policies. If we do not accept your insurance plan, payment is expected in full at the time of service. If we do, then your estimated out of pocket expense is expected at the time of services. I agree not to hold Orlando Lifestyle Dentistry responsible for knowing what my insurance company pay or will allow for any procedure. _____ **Initial**

Proof of Insurance

I understand that I am responsible for giving my current insurance information to Orlando Lifestyle Dentistry on or before the day of services. This will be completed by providing the new information for insurance and any updates in address, phone number or other pertinent information. If I fail to do this I understand that the balance becomes my immediate responsibility. _____ **Initial**

Claims Submission

I understand that Orlando Lifestyle Dentistry will allow my insurance company 30 days (the time allowed by the insurance commissioner in the State of Florida) in which to pay or deny my claim. When requested I agree to provide any necessary information to my insurance company in order to process my claim in a timely manner. _____ **Initial**

I understand that my insurance company may fail to pay in accordance with my treatment plan estimate and payment becomes my responsibility. If I have questions regarding why my insurance did not pay as expected, I understand that it is my responsibility to contact my insurance company. Please remember that your insurance contract is between you and your insurance carrier; we are not party to that contract and we are not responsible for knowing the guidelines of that contract.

_____ **Initial**

Co-Payments and Deductibles

I understand that I am responsible for my co-payments and deductibles on the day services are rendered. In addition, I understand that treatment plans are only an **estimate** and I may owe additional fees to Orlando Lifestyle Dentistry after payment is made by my insurance company. _____ **Initial**

Deposits

I understand that when making a reservation for a time on the schedule for a fee of $500 or more, it is Orlando Lifestyle Dentistry policy that a deposit of at least half of the out of pocket be collected at the time the appointment is scheduled, and that I will pay the remaining on the day of services.

_____ **Initial**

Balances and Unpaid Balances

I understand that Orlando Lifestyle Dentistry will send ONE statement if I have a balance. I agree to pay my balance with in 30 days from the date of the statement. _____ **Initial**

I understand my account will accrue a $10.00 late fee every month I fail to pay my balance. I understand that my account will be sent to a collection agency if I fail to pay my balance within 90 days of the first statement. Further, I understand that and additional 30% will be added to my balance upon submission of my account to the collection agency. _____ **Initial**

Missed Appointments

I understand that if I do not cancel a scheduled appointment within 48 hrs of the appointment, I will be charged a "no show" fee in the amount of $35 for cleanings and check up's and $45 per hour for treatment. I understand that cancelations are not accepted by leaving a voice message and I must speak to a scheduling coordinator to cancel or reschedule an appointment. _____ **Initial**

By signing below I certify that I have read and understand the information about the Payment Policies for Orlando Lifestyle Dentistry.

Signature:_____ Print Name:_____

Date:_____

ORLANDO LIFESTYLE IMPLANT DENTISTRY
6000 Turkey Lake Rd #109
Orlando, FL 32819
Phone: 407-XXX-XXXX

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been given a copy of Orlando Lifestyle Implant Dentistry's Notice of Privacy Practices. I may also request a copy for my personal records if I wish.

Patient Name_____

Signature_____

Date:_____

We attempted to obtain written acknowledgement of receipt of privacy practices, but it could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining the acknowledgement
_____ Other: (list)_____
_____