TrueSmiles Dental Studio
www.truesmilesdentalstudio.com info@truesmilesdentalstudio.com
1928 Highland Oaks Blvd. •Lutz, FL 33559-7323 813-949-0424

WELCOME TO OUR PRACTICE

NAME _____ DOB _____ SS _____

ADDRESS _____

HOME # _____ CELL # _____ EMAIL _____

How did you hear about us: _____ ◻ MARRIED ◻ SINGLE ◻ CHILD ◻ OTHER

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INSURANCE INFORMATION

Policy Holder: _____ DOB: _____

Relationship: _____

Insurance Co.: _____

Employer Name: _____

ID# _____ Grp # _____ Ph # _____

◻ ***By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand I am financially responsible for all charges, whether or not paid by insurance.

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED

Emergency Contact _____ Relationship _____

Phone # _____

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HIPAA ACKNOWLEDGEMENT

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance of an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used, or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature _____ Date _____

MEDICAL HISTORY

Have you been hospitalized for any surgical operations or serious illness in the past year?
If yes, please explain: _____

Are you currently taking any medication[s] including non-prescription medicine?
If yes, please explain: _____

Do you have any health problems from the last year that need further clarification? ◻ YES ◻ NO
If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? ◻ YES ◻ NO
Do you use controlled substances? ◻ YES ◻ NO
Do you smoke/chew tobacco? ◻ YES ◻ NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO THE FOLLOWING?

Local Anesthetics	◻ YES	◻ NO	Penicillin/Tetracycline/or any other antibiotic[s]	◻ YES	◻ NO
Sulfa Drugs	◻ YES	◻ NO	Codeine	◻ YES	◻ NO
Sedatives	◻ YES	◻ NO	Iodine	◻ YES	◻ NO
Aspirin	◻ YES	◻ NO	Metal	◻ YES	◻ NO
Latex	◻ YES	◻ NO	Other [please specify] _____		

MEDICAL CONDITIONS [Please circle the ones that apply to you]:

Allergies [Seasonal/Pollen/Dust]	Excessive Bleeding	Kidney / Liver Disease
Anemia	Excessive Thirst	Leukemia
Angina / Chest Pain	Fainting / Seizures	Mitral Valve Prolapse
Arthritis / Gout	Glaucoma	Nursing
Artificial Joint	Heart Attack / Failure	Pregnant / Trying to Get Pregnant
Asthma	Heart Disease	Taking Oral Contraceptives
Cancer	Heart Pacemaker	Rheumatic Fever
Chemotherapy / Radiation	Heart Murmur	Sudden Weight Loss / Gain
Diabetes	Hepatitis A B C	Swelling of Limbs
Drug Addiction	Herpes	Thyroid Conditions _____
Emphysema	High / Low Blood Pressure	Tuberculosis _____
Epilepsy / Convulsions	HIV / AIDS / HPV	Other _____

If any condition or alerts selected above needs further clarification, please explain:

_____

_____

Name [please print] _____

Signature _____ Date _____

Doctor / Hygienist Signature _____ Date _____

CONSENT FOR SERVICES AND FINANCIAL POLICY

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

Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collection 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 if 1 ½% 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 any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five [5] days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, inwriting, within the time payment is due. 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 permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Name [please print] _____

Signature _____ Date _____

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information [including account, appointment and clinical information] to the secured website for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me, and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person tor entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligation with respect to patient confidentiality that limit eh ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, discloser, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MSUSE OF PATIENT INFORAMTION OR OTHER INFORAMTION TRASNMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Name [please print] _____

Signature _____ Date _____