NAME
NOMBRE ______
ADDRESS
DIRECCION ______
CITY & STATE & ZIP CODE
CIUDAD, STATE & CÓDIGO POSTAL ______
PHONE NUMBER
TELEFONO ______ E-MAIL : ______
AGE
EDAD ______ BIRTHDATE:
FECHA DE NACIMIENTO ______ MARITAL STATUS
ESTADO CIVIL ______
SEX
SEXO ______ SOCIAL SECURITY NUMBER
NUMERO DE SEGURO SOCIAL ______
INSURANCE COMPANY
COMPAÑIA DE SEGURO ______
SPOUSE/PARENT
ESPOSO (A)/PADRES ______
RESPONSIBLE PARTY
PERSONA RESPONSABLE ______
EMPLOYER
LUGAR DE EMPLEO ______
ADDRESS
DIRECCION ______
CITY & STATE & ZIP CODE
CIUDAD, STATE & CÓDIGO POSTAL ______
WORK PHONE
TELEFONO DEL TRABAJO ______
CELL PHONE
NÚM. DE TELÉFONO CELULAR ______
PHYSICIAN PHONE NO. ______
NOMBRE DE SU MEDICO ______ TELEFONO ______

REFERRED BY/REFERIDO POR ______

DATE
FECHA ______

WELCOME BIENVENIDO

		Yes	No
1.	ARE YOU UNDER THE CARE OF A PHYSICIAN? ¿ESTA USTED BAJO EL TRATAMIENTO DE ALGUN MEDICO? REASON RAZON ______	☐	☐
2.	ARE YOU TAKING ANY MEDICINE OR DRUGS? ¿ESTA USTED TOMANDO ALGUN MEDICAMENTO O DROGA? LIST/ NOMBRELOS ______	☐	☐
3.	HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? ¿HA ESTADO USTED HOSPITALIZADO EN LOS PASADOS 5 AÑOS? WHY? ¿POR QUE? ______	☐	☐
4.	ARE YOU ALLERGIC TO ANYTHING (DRUGS, FOOD)? ¿ES USTED ALERGICO A ALGO (MEDICINAS, COMIDAS)? LIST/ NOMBRELOS ______	☐	☐
5.	HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING? ¿HA TENIDO O TIENE USTED ALGUNO DE LOS SIGUIENTES?	☐	☐
	HEART TROUBLE PROBLEMAS DE CORAZON ______	☐	☐
	RHEUMATIC FEVER FIEBRE REUMATICA ______	☐	☐
	DIABETES DIABETIS ______	☐	☐
	HEART MURMUR SOPLO DEL CORAZON ______	☐	☐
	HIGH BLOOD PRESSURE PRESION ALTA O BAJA ______	☐	☐
	LIVER DISEASE (HEPATITIS) PROBLEMA DEL HIGADO (Hepatitis) ______	☐	☐
	EPILEPSY (SEIZURES) EPILEPSIA ______	☐	☐
	CANCER CANCER ______	☐	☐
	TUBERCULOSIS TUBERCULOSIS ______	☐	☐
	ANEMIA ANEMIA ______	☐	☐
	BLOOD DISEASE PROBLEMAS DE SANGRE ______	☐	☐
	ASTHMA ASTHMA ______	☐	☐
	A.I.D.S. – S.I.D.A. ______	☐	☐
6.	DO YOU SMOKE? PACKS PER DAY ¿USTED FUMA? ______	☐	☐
7.	ARE YOU PREGNANT? ¿ESTA USTED EMBARAZADA? ______	☐	☐

UPDATES

DATE
FECHA ______

DATE
FECHA ______

DATE
FECHA ______

DATE
FECHA ______

DATE
FECHA ______

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES ON SERVICES RENDERED TO ME.
YO ENTIENDO QUE SOY RESPONSABLE POR EL PAGO DE LOS SERVICIOS PRESTADOS.

CONSENT/CONSENTIMIENTO
I AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
YO AUTORIZO EL PAGO DIRECTO AL DENTISTA DE LOS BENEFICIOS DEL SEGURO QUE DE OTRA FORMA SERIAN PAGADOS A MI.

SIGNATURE/FIRMA ______
(RESPONSIBLE PARTY IF MINOR)(PERSONA RESPONSABLE SI MENOR)

DENTIST SIGNATURE ______
FIRMA DEL DENTISTA

NAME ______ ADDRESS ______
TELEPHONE # HOME ______ WORK ______ CELL ______

Welcome to our practice!

Our office intends to provide YOU the best dental care. We believe that service to our patients is at its best when there is a complete mutual understanding and cooperation.
Please understand our financial policy.

Payment of all professional services are the **sole** responsibility of the patient **regardless** of insurance coverage. **YOU are responsible for any amounts not paid or covered by your insurance carrier. Any** changes on your coverage must be notified on a timely manner.

Payment is due on the treatment day for all copays, deductibles or non-covered services. We don't offer payment plans. We offer a pre-payment plan in which you make payment untilyou reach an amount equivalent to the planned treatment. Financing is availabe through Care Credit, if you must qualify. Our office participates on some of their plans.

YOU understand that verification of benefits with your insurance carrier is in **No Way a Guarantee of Coverage or Payment** at the time the claim is filed.

Your insurance carrier will only provide **"an estimate"** of the percentages payable under your plan. They are not bound or promise to pay that or any amount. Final amount will be known when claims are processed and you have available funds on your yearly maximum.

Any payment you receive from your dental carrier must be forwarded to our office.

We do not accept insurance assignment without an approved predetermination. If you request we start a procedure prior to receiving approval, a statement must be sign stating you will be **100%** responsible for payment if the claim is denied.

We do not bill secondary insurances, everything you need to file will be provided at no cost to you.

A $25.00 service fee will be assesed for missed or appointments cancelled the same day. You may be dismisssed from the office after 3 missed or cancelled appointment on the same day. Only 2 family members will be given appointments on any given day to avoid multiple cancelations.

Unpaid balances will be forwarded to a collection agency after 60 days. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Returned checks will be subject to the maximum fee allowed by the Office of the Florida State Attorney and if unpaid will be referred for prosecution. Check $.01 to $50.00 -$25 service charge allowed; $50.01 to $300- $30 service charge allowed; check over $300- $40 or %5 service charge allowed.

____________________ patient / guardian

____________________ date

PAYMENT OPTIONS

We will accept payment in:

1. Cash
2. Money orders
3. Credit and debit cards (Visa, Master Card, Discover and American Express).

If a family member that is not our patient will pay for your treatment we require a copy of their driver's license, their credit card (both sides) and a written authorization stating we can charge their card and the amounts to charge.

4. Care Credit and Lending Tree. These companies offer financing and are credit based. We participate on some of their plans. Once you qualify, you must select a plan and the total amount will be financed at once. The selected plan cannot be modified. Family members can share a plan. Billing questions must be forwarded to Care Credit or Lending Tree.

I understand the payment options available

______________________________ ______________________________

signature patient/guardian date

ABOUT TREATMENT PLANS AND INSURANCE PAYMENTS

Extensive treatment will be submitted to your dental insurance for approval. Treatment is recommended according to your needs and not to your coverage. Please understand your employer purchases a coverage that may or may not include the treatment you need. You may be provided alternatives for treatment. You must decide on an option you a willing to commit to.

It takes a dental insurance about 4 weeks to reply to a proposed treatment. If you decide not to wait, we will ask you to sign an authorization to start prior to receiving this approval. In the event your dental carrier declines payment, you will be responsible for the total cost of the treatment.

I understand unpaid claims will be my responsibility after 60 days.

Non covered procedures will be billed at our regular fee.

Please remember that you dental insurance is a contract between you, your employer and the dental plan. **You must inform us of any changes in coverage**

I understand what treatment plans are and my financial responsibility for non-paid procedures.

______________________________ ______________________________

signature patient / guardian date

Acknowledgement of Receipt of Privacy Practices

I have received a copy of GranDental Center Notice of Privacy Practices and I agree to its terms.

______________________________ ______________________________
Print Name Date

____
Signature Patient/Guardian

<u>YOU CAN REFUSE TO SIGN THIS CONSENT BUT YOU AGREE TO PAY FOR YOUR DENTAL TREATMENT IN FULL</u>

I authorize GranDental Center to release the following personal health information for:

Dental Services: Treatment, Insurance Claims and Payment

Prescriptions, Referrals to Specialists and Communication with your primary doctor

Doctor__________________________ Pharmacy__________________________

And as required by law.

You give us permission to contact you for appointment reminders, payment and healthcare operations. Please cross out any option you don't agree too.

Home or Cell Phone (Text included)

Fax#________________________

Letter/Post Card

Work Telephone#______________

Email________________________

Personal Representative ____
Name and Phone Number

If you are 18 years of age or older, please indicate who is financially responsible for your dental expenses. **This person must be here to agree and sign.**

Responsible Financial Party____

Signature____
Your financial responsible party must also be your Personal Representative because they will pay for your treatment.