# Regency Dental

## WELCOME

**We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you maintaining your dental health.**

## PATIENT INFORMATION:

**Name:**_____ **Cell Phone ( )**_____
*Last* *First* *Middle*
**Home Phone: ( )**_____ **Social Security #:**_____**Date of Birth:**_____
**Address:**_____ **E-mail:** _____
**City:**_____**State:**_____ **Zip Code:**_____

**Sex:** ☐ **Male** ☐ **Female** **Age:**_____**Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐
**Patient Employer:**_____ **Occupation:**_____
**Business Address:**_____ **Phone:**_____
**In case of an emergency, who should be notified:**_____ **Phone Number:**_____
*Name*
**Whom may we thank for referring you:**_____

## DENTAL INSURANCE:

**Person Responsible for account:**_____
*Last Name* *First Name*
**Relationship to patient:**_____**Birthdate:**_____**Social Security#**_____
**Address (*if different from patient*):**_____**Phone:**_____
**City:**_____**State:**_____**Zip Code:**_____
**Person Responsible Employed By:**_____**Occupation:**_____
**Business Address:**_____**Phone:**_____
**Insurance Company:**_____**Contact #: ( )**_____**Group #:**_____ **Subscriber #:**_____
**Names of other dependents covered under this plan:** _____

## MEDICAL HISTORY:

1. Are you in good health now?……... ☐ Yes ☐ No
2. Are you now under the care of a physician…… ☐ Yes ☐ No
   If so, what is the condition being treated?_____Physcian's Name:_____
   Address: _____Phone #:_____
3. Date of last medical examination_____
4. Have you ever been hospitalized or had a serious illness?…….. ☐ Yes ☐ No
5. Have you had excessive bleeding requiring special treatment?…….☐ Yes ☐ No
6. Are you currently taking any medication?…… ☐ Yes ☐ No
   Please list name of medication, purpose, & dosage below:
   1._____ 2._____ 3. _____
7. Are you **allergic** or have you ever experienced any reaction to the following?
   Local Anesthetics (e.g. Novocain) ……☐ Yes ☐ No
   Barbiturates/Sedatives/Sleeping Pills… ☐ Yes ☐ No
   Penicillin/Other antibiotics…… ☐ Yes ☐ No
   Aspirin……☐ Yes ☐ No
   Codeine or other Narcotic…….. ☐ Yes ☐ No
   Sulfa Drugs…… ☐ Yes ☐ No
   Other Allergies _____
8. (Women) Are you pregnant?…… ☐ Yes ☐ No If so, give due date_____
   Are you nursing?…… ☐ Yes ☐ No
   Are you taking Birth Control Pills? (Antibiotics may make birth control pills ineffective)…… ☐ Yes ☐ No

Do you have or have you ever had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Heart failure…… | □ Yes | □ No | Tumors or growths…….. | □ Yes | □ No |
| Heart Disease…….. | □ Yes | □ No | Cancer...…… | □ Yes | □ No |
| Angina Pectoris…….. | □ Yes | □ No | X-Ray or Cobalt Treatment…….. | □ Yes | □ No |
| High Blood Pressure…….. | □ Yes | □ No | Chemotherapy…….. | □ Yes | □ No |
| Heart Murmur …… | □ Yes | □ No | Arthritis……. | □ Yes | □ No |
| Rheumatic Fever……. | □ Yes | □ No | Cortisone Medicine…….. | □ Yes | □ No |
| Congenital Heart Lesions…… | □ Yes | □ No | Pain in Jaw Joints…… | □ Yes | □ No |
| Scarlet Fever…… | □ Yes | □ No | Glaucoma…… | □ Yes | □ No |
| Damaged or Artificial Heart Valves…….. | □ Yes | □ No | Aids……. | □ Yes | □ No |
| Heart Pacemaker……. | □ Yes | □ No | Hepatitis A (Infectious)…… | □ Yes | □ No |
| Heart Surgery…….. | □ Yes | □ No | Hepatitis B (Serum)……. | □ Yes | □ No |
| Artificial Joint……..…… | □ Yes | □ No | Liver Disease…….. | □ Yes | □ No |
| Anemia……. | □ Yes | □ No | Yellow Jaundice …….. | □ Yes | □ No |
| Stroke ……. | □ Yes | □ No | Blood Transfusion …….. | □ Yes | □ No |
| Kidney Trouble …….. | □ Yes | □ No | Drug Addiction …… | □ Yes | □ No |
| Ulcers ……. | □ Yes | □ No | Hemophilia ……. | □ Yes | □ No |
| Emphysema …… | □ Yes | □ No | Venereal Disease (Syphilis, Gonorrhea).. | □ Yes | □ No |
| Cough ……. | □ Yes | □ No | Cold Sores …… | □ Yes | □ No |
| Tuberculosis (TB) …….. | □ Yes | □ No | Epilepsy or Seizures …… | □ Yes | □ No |
| Asthma …… | □ Yes | □ No | Fainting or Dizzy Spells ……. | □ Yes | □ No |
| Allergy, Hay fever, Sinus …….. | □ Yes | □ No | Psychiatric Treatment …….. | □ Yes | □ No |
| Metal Sensitivity …… | □ Yes | □ No | No Sickle Cell Disease …… | □ Yes | □ No |
| Diabetes ……. | □ Yes | □ No | Bruise Easily …… | □ Yes | □ No |
| Thyroid Disease …….. | □ Yes | □ No | | | |

10. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor said you cannot do? If so, explain:_____

## DENTAL HISTORY

1. Reason for this visit? _____
2. Last dental visit? _____ Purpose _____ Last complete exam _____
3. Do you prefer local anesthetic (Novocain) for most dental treatment? ……... □ Yes □ No
4. Have you ever had any serious trouble associated with previous dental treatment? _____
5. Does dental treatment make you nervous? □ No □ Slightly □ Moderately □ Extremely
6. Have you ever been treated for periodontal disease (Gum Disease, Pyorrhea, Trench Mouth)?……. □ Yes □ No
   If so, when? _____
7. Do you have or have you ever had the following?

| | | | | | |
|---|---|---|---|---|---|
| Bleeding Sore Gums……. | □ Yes | □ No | Loose Teeth…….. | □ Yes | □ No |
| Unpleasant Taste/Bad Breath…… | □ Yes | □ No | Sensitive to Hot…… | □ Yes | □ No |
| Burning Tongue/Lips…… | □ Yes | □ No | Sensitive to Cold…….. | □ Yes | □ No |
| Frequent Blisters, Lips, Mouth……. | □ Yes | □ No | Sensitive to Sweets…… | □ Yes | □ No |
| Swelling/Lumps in Mouth…… | □ Yes | □ No | Sensitive to Biting …… | □ Yes | □ No |
| Ortho Treatment (Braces)……. | □ Yes | □ No | Food Impaction……. | □ Yes | □ No |
| Biting Cheeks/ Lips…….. | □ Yes | □ No | Clenching/Grinding……... | □ Yes | □ No |
| Clicking/Popping Jaw…….. | □ Yes | □ No | Complications from Extractions……... | □ Yes | □ No |
| Difficulty Opening or Closing Jaw…….. | □ Yes | □ No | Cigarettes, Pipe, Cigar Smoking…….. | □ Yes | □ No |

**Preferred Method of Payment:** □ **Cash** □ **Check** □**Credit Card (MasterCard, Visa, Discover, CareCredit)**

There is a minimum $20.00 charge for all returned checks.

**Appointments:** **A charge of 10% of the total cost of the appointment may be applied for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.**

*I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.*

Signature (Parent or Guardian, if Patient is a minor):_____ Date: _____

Dentist's Signature: _____ Date: _____

# Regency Dental

466 S.W. Port St. Lucie Blvd.
Port St. Lucie, FL 34953
Fax: 772-785-9062

910 S.W. St. Lucie West Blvd.
Port St. Lucie, FL 34986
Fax: 772-785-5308

10430 SW Village Center Drive
Port St. Lucie, FL 34987
Fax: 772-345-2104

772-785-9515

**Our Financial Policy**
Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we required that you read, agree to sign prior to any treatment.

- All patients must complete our "Patient Information Form" before seeing the doctor.
- Full payment is due at time of service. Any amounts not paid in full within 30 days will be subject to a finance charge of 1.5% compounded or $10.00, whichever is greater. Delinquent accounts may be assigned to our collection agency and you will be responsible for all collection fees.
- We accept cash, Visa, MasterCard, Discover, Capital One, and CareCredit

**Regarding Insurance**
We may accept assignment of insurance benefits, however 20-50% of the bill is to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a part to that contract. If your insurance company has not paid your account in full within 45 days, the balance of your account will be due. Please be aware some and perhaps all of the services provided may be "non-covered" services and not considered reasonable and necessary under your insurance.

Regardless of the insurance company's determination of usual and customary rates or amount of assignment, you are required to pay the full amount charged.

**Adult Patients**
Adult patients are responsible for payment at time of service.

**Minors**
The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, or payment by cash at time of service has been verified.

**Missed Appointments**
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. One of our goals is to reduce the cost of billing and thereby keep the costs of our services as low as possible to all patients. Please let us know if you have any questions or concerns.

**I have read, understand, and agree to the above Financial Policy**

**Patient or Responsible Party_____Date_____**

**Co-Responsible Party _____Date_____**

## Your Rights Regarding Medical/Dental Information About You.

Regency Dental is committed to protecting medical and dental information about you. This Notice describes Regency Dental's privacy practices and that of all its employees and staff. This Notice will tell you about the ways in which we may use and disclose medical/dental information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical and dental information. We are required by law to:

- **Give you this Notice of our legal duties and privacy practices with respect to medical and dental information about you.**
- **Make sure that medical and dental information that identifies you is kept private; and**
- **Follow the terms of the Notice that is currently in effect.**

### HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

The following categories describe different ways we use and disclose medical information. For each category we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the listed categories.

**Treatment:** We may use and disclose medical/dental information about you to provide you with dental treatment and services. For example, we may disclose the last time you had a cleaning or x-rays with a specialists that we may refer you to, so they are able to coordinate their treatment plans accordingly.

**Payment:** We may use and disclose medical/dental information about you so that the treatment and services you receive at Regency Dental may be billed and payment may be collected from you, and insurance company, or a third party. For example, we may need to give your insurance company information and x-rays in regards to serviced performed on you so your insurance company will either pay us or reimburse you for the services.

**Office Operations:** We may use and disclose medical/dental information about you for Regency Dental operations. These uses and disclosures are necessary to the Operation of Regency Dental, and make sure that all or our patients receive quality care. For example, we may use your information to discuss with our Hygienist in regards to the type of cleaning you may need.

**Appointment Reminders:** We may use and disclose medical/dental information to contact you as a reminder that you have an appointment for treatment at Regency Dental.

**Treatment Alternative:** We may use and disclose medical/dental information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Dental-Related Benefits and Services:** We may use and disclose medical/dental information to tell you about dental-related benefits or services that may be of interest to you.

**Individuals Involved in Your Care of Payment for Your Care:** We may release medical/dental information about you to a close personal friend or family member who is involved with your dental care or payment of your care,

So long as you have not objected and it is reasonable for us to infer that such disclosure is in your best interest. We may also tell that person that you are at Regency Dental and your general condition.

**Special Purposes When Permitted or Required by Law:** We may disclose medical/dental information about you as for special purposes when permitted or required by law, including by not limited to the following.

- **To avert a serious threat to health or safety against you, the public, or another person.**
- **For public health and administrative oversight activities such as disease control, abuse, or neglect reporting, health and vital statistics, audits, and licensure reviews.**

**For research purposes limited information may be disclosed as permitted by law.**

- **For organ and tissue donation and transplant to facilitate organ or tissue donation and transplant.**
- **To worker's compensation or similar programs for the payment of benefits for work-related injuries.**

- **To coroners, medical examiners, and funeral directors to identify a deceased person, cause of death, or to carry out duties.**
- **To comply with court orders judicial proceedings, or other legal processes related to law enforcement, custody of inmates, legal and administrative actions, and criminal activities**
- **For U.S. Military and veteran reporting regarding members and veterans of the armed forces of U.S. or foreign military.**
- **For national security and intelligence activities such as protective services for the President and other authorized persons.**

**State and Other Federal Laws:** Regency Dental will comply with all applicable state and federal laws. For example, under state law, there are more limits on the disclosure of HIV and AIDS information. Regency Dental will continue to abide by all applicable state and federal laws.

**Other Uses of Medical/Dental Information Require an Authorization:** Other uses and disclosures of dental information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us an authorization to use or disclose medical/dental information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose information about you for the reasons covered by the written authorization. You understand that we are unable to take back any disclosures that we have already made with your authorization, and that we are required to retain our records of the care that we provide to you.

**Your Right to Inspect and Copy:** You have the right to inspect and copy dental information that may be used to make decisions about your care. We may charge a reasonable fee for the costs of copying , mailing or other supplies associated with your request.

**Your Right to Amend:** If you feel that medical/dental information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to add a statement. You must provide a reason that supports your request for an amendment.

**Your Right to Accounting of Disclosures:** You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of dental information about you. Your request must state a time period. We may limit the time period to 5 years and disclosures made on or before January 1, 2003. The first list your request within a 12-month period is free. For additional lists, we may charge you for the costs of providing the list.

**Your Right to Request Confidential Communications:** You have the right request that we communicate with you about dental matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.. We will accommodate all reasonable requests.

**Right to File a Complaint:** If you believe your privacy rights have been violated, or you have a complaint , you may file a complaint with Regency Dental. You may also file a complaint directly with the Secretary of the Department of Health and Human Services. **You will not be penalized in any way for filing a complaint.**

## CHANGES TO THIS NOTICE

We reserve the right to change the Notice., to make the revised or changed notice effective for information we already have about you as well as any information we receive in the future. We will make copies available upon request.

You have many rights with regard to your dental information. If you wish to exercise any of these rights, please submit your written request to:

**Brandi M., Privacy Officer**
**910 SW St. Lucie West Blvd.**
**Port St. Lucie, FL 34986**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**REGENCY DENTAL**
You May Refuse to Sign This Acknowledgment

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Regency Dental** this ___ day of _____, 20__. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Please print your name

_____
Please sign your name

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority _____.

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Brandi

**Office Use Only**

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

| | |
|---|---|
| It was emergency treatment | ____ |
| I could not communicate with the patient | ____ |
| The patient refused to sign | ____ |
| The patient was unable to sign because | ____ |
| Other (please describe) | ____ |

_____
Signature of privacy officer

## PATIENTS WITH INSURANCE:

The treatment estimate being presented to you is only an **Estimate** of what your insurance is expected to pay towards the following treatment. The estimate is based on the information provided to us by you and your insurance company. If your insurance company does not make the estimated payment, it is solely your responsibility to make payment in full to Regency Dental, at such time. Regency Dental offers insurance claim filing services as a courtesy to our patients, but ultimately it is a contract between you and your insurance company.

I, _____ have fully read and understand the above statement and understand that I am responsible to pay if my insurance company does not pay for any reason.

Patient's Signature: _____ *(Parent or Guardian if patient is a minor.)*

Patient Name: _____ Date signed:_____
*(Please Print)*

Witness: _____Date signed:_____

# Regency Dental

Regency Dental
910 SW St. Lucie West. Blvd.
Port St. Lucie, FL 34986
(772) 785-9515

Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: **Regency Dental**

**910 SW St. Lucie West Blvd.**
**Port St. Lucie, FL 34986**

Or

If my current policy prohibits payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

**C/o Regency Dental**
**910 SW St. Lucie West Blvd.**
**Port St. Lucie, FL 34986**

For the professional or dental expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Regency Dental to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

**Dated at: _____this _____day of _____, 20_____**

_____ _____
Signature of Policyholder Witness

# IMPORTANT INFORMATION YOU SHOULD KNOW ABOUT YOUR INSURANCE COVERAGE

Here at Regency Dental our mission is to provide each patient the highest quality of care. In our effort to suggest the best treatment options to our patients, we do not make decisions based upon what your insurance company allows. We make decisions based on the highest quality of products and procedures available. We will provide to you a treatment plan estimate based upon the basic information provided to us by you and your insurance company. The treatment plans are not intended to serve as a guarantee of payment by your insurance company, and at no time should be thought as such.

It is **your** responsibility to know what your insurance plans policies limits and exclusions are. Following are some suggestions of questions you might want to ask your insurance company.

- Find out if your insurance company downgrades posterior composites (white fillings) to amalgam (silver filling) rates. If so, ask them what your portion will be for the composite restoration.
- Ask your insurance company what tooth numbers are covered for sealants, and to what age.
- Find out if you have a missing tooth clause, replacement clause, or a waiting period for any services.

These are just a few suggestions of common questions that are often asked to insurance companies. If you would like to know exactly what your financial obligation should be, you are encouraged to call your insurance company and ask what your portion will be for each ADA code on your personal treatment plan, or you can ask for a "Pre-Treatment Estimate" to be filed with your insurance company. Please be aware that it can take up to 6 to 8 weeks to get a Pre-Treatment Estimate back from your insurance company, and we will help facilitate this process at your request.

***I have read and understand the above information. I understand that Regency Dental is not responsible or capable of providing to me information in regards to what my insurance companies payments will or will not be.***

| | |
|---|---|
| _____ | _____ |
| *Signature of Patient or Authorized Agent* | *Date* |
| _____ | _____ |
| *Name (Please Print)* | *Daytime Phone Number* |