



Welcome

91 Branscomb Road, Unit 7
Green Cove Springs, Florida 32043

PATIENT LAST NAME: _____ FIRST: _____ INITIAL: _____

How do you wish to be addressed? _____ DOB _____

(☐ Single ☐ Married ☐ Divorced) (☐ Male ☐ Female) Full time Student? ☐ Yes ☐ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____ Soc. Sec. No. _____

Dental Insurance Co. _____ Member ID _____ Group # _____

Is patient covered by another dental insurance? ☐ Yes ☐ No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

SPOUSE, PARENT OR RESPONSIBLE PARTY

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

EMERGENCY CONTACT

Last Name _____ First _____ Initial _____

Address _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to Dr. April Stone, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

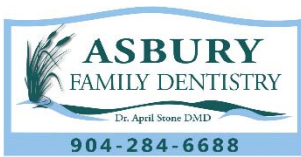
Signature _____ Date _____

Relationship to Patient _____

PATIENT ENROLLMENT

www.AsburyFamilyDentistry.com

Tel. (904) 284-6688 Fax (904) 212-2333



PATIENT LAST NAME: _____ PATIENT FIRST NAME: _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:

	Yes	No		Yes	No	
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Head, neck, jaw pain, or aches	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain _____
Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>	
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>	
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Cigarette, pipe, or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had trouble from previous dental care? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain _____
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure or irritants	<input type="checkbox"/>	<input type="checkbox"/>	
Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	(cold, heat, sweets)			
Growths or sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____			
Gums swollen, tender or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____			

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____ Blood Pressure _____

Have you had any serious illnesses or operations Yes ☐ No ☐ If yes, please describe _____

Have you ever had a blood transfusion Yes ☐ No ☐ If yes, give approximate dates _____

(Women) Are you pregnant? Yes ☐ No ☐ Due date _____ Nursing? Yes ☐ No ☐ Taking birth control pills? Yes ☐ No ☐

Please check if you have/had:

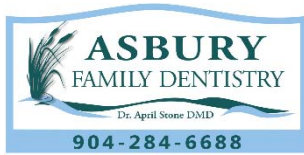
	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis type _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head/neck	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Required Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	Any immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Have you used steroids	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Date of last episode _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with operations or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease, clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently under the care of a Physician?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic/sensitive to Latex?	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatments	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to Penicillin, Aspirin, or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please specify _____		
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	List any medications that you are taking:		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Slow healing wounds	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____		

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

DENTAL & MEDICAL HEALTH HISTORY



SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: Hunter Goertz
Telephone: (904) 284-6688 **Fax:** (904) 212-2333
Address: 91 Branscomb Road, Unit 7, Green Cv Springs, FL 32043

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: FOR OFFICE USE ONLY

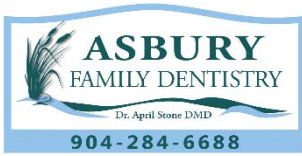
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

HIPAA CONSENT FORM



PATIENT NAME: _____ DATE: _____

Thank you for choosing Asbury Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS

Full payment is due at time of service. We accept:

- Cash, Visa, MasterCard, American Express or Discover Card. **We do not accept personal checks.**
- Convenient Monthly Payment Options¹ from CareCredit Healthcare Credit Card, which allows you to pay over time.

INSURANCE

Asbury Family Dentistry provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is **estimated** and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Asbury Family Dentistry staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to Asbury Family Dentistry. However, if you are paid by the insurance company instead of Asbury Family Dentistry, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of \$25, or the amount allowed by law.

MISSED APPOINTMENTS

A fee of \$30 is charged for patients who miss or cancel their appointment without 24-hour notice. You will be expected to pay this fee before rescheduling your treatment. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____ Date _____

¹ Subject to credit approval