West Broward Dental Associates, PLLC
2024

Name: _____ Male_____ Female _____
Last First

Email Address: _____

DOB: _____/_____/_____ Age: _____ Social Security #_____-_____-_____

Home Address: _____
Street City State Zip

Home # _____ Cell #_____ Employer: _____

HOW DID YOU HEAR OF OUR OFFICE? _____

In Case of an Emergency: Name: _____ Phone #: _____Relation: _____

MEDICAL HISTORY:

Physician Name: _____ Phone #: _____

Have you had any recent medical surgeries? Y/N if so please explain _____

Have you been instructed to premedicate prior to dental treatment? Y / N

For Women: Are you taking birth control pills? Y / N Pregnant? Y / N Nursing? Y / N

Any Medical Conditions? Please list all:
_____

Are you taking any Prescription Medication or Non-Prescribed Pills/Drugs? Please list all: _____

Preferred Pharmacy Name: _____ Number: _____

Do you or HAVE YOU EVER EXPERIENCED the following? * PLEASE CIRCLE**

Abnormal Bleeding	Colitis	Hay Fever	Liver Disease	Shingles
Alcohol Abuse	Congenital Heart Defect	Headaches	Low Blood Pressure	Sickle Cell
Anemia	Diabetes	Heart Attack	Lupus	Sinus Problems
Arthritis	Difficulty Breathing	Heart Murmur	Mitro Valve Prolapse	Steroid Therapy
Artificial Bones/ Joint	Drug Abuse	Heart Surgery	Pacemaker	Stroke
Artificial Valves	Emphysema	Hemophilia	Persistent Cough	Thyroid Problems
Asthma	Epilepsy	Hepatitis	Radiation Treatment	Tuberculosis TB
Cancer	Fainting Spells	High Blood Pressure	Rheumatic Fever	Ulcers
Chemotherapy	Fever Blisters	HIV+ / AIDS	Scarlet Fever	Venereal Disease
Chicken Pox	Glaucoma	Kidney Problems	Seizures	Tobacco use
Take Aspirin Daily	Blood Thinners	Metal Pins	Stress	Osteoporosis

Are you ALLERGIC to any of the following? PLEASE CIRCLE

Aspirin Barbiturates	Codeine Dental Anesthetics	Erythromycin Jewelry / Metals	LATEX PENICILLIN	Sedatives Sulfa drugs	Tetracycline Other

Please list anything additional that causes allergic reactions: _____

Patients Name: _____Patients Signature: _____Date: _____/_____/_____

Doctor's Signature: _____ Date: _____/_____/_____

Smile Evaluation Form

- **Are you happy with the appearance of your teeth/gums/smile?.....Yes/ No**

- **Would you like to discuss enhancing the appearance of your smile?.....Yes/No**

- **What don't you like about your smile?**

  _____

- **Would you like to discuss how to make your teeth white?.....Yes/No**

- **Do you have any dental anxiety?.....Yes/No**

HIPPA Release Form

Patient Name: _____ Date of birth: _____/_____/_____

Release of Information:
I authorize the release of information including the diagnosis, records, treatment plans, X-rays or claim information.

The information may be released to:

( ) Spouse/Partner Name: _____

( ) Children Name: _____

( ) Name Other: _____

( ) DO NOT RELEASE TO ANYONE

This release will remain in effect until terminated by me in writing. Messages: Please call:

( ) My home ( ) My work ( ) My cell ( ) Other _____

If unable to reach me:
( ) You may leave a detailed message
( ) Leave a message asking for me to return your call

Patient Signature: _____ **Date**: _____/_____/_____
(Parent if Minor or Responsible Party)

Minor Medical Treatment Authorization and Consent

I,_____ the parent of _____ authorize _____ to seek, obtain and consent treatment as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of West Broward Dental Associates, PLLC and is effective_____/_____/_____until_____/_____/_____.

Parent name: _____

Parent Signature: _____ Date: _____/_____/_____

WELCOME TO WEST BROWARD DENTAL ASSOCIATES. IN ORDER TO MAINTAIN THE HIGHEST QUALITY OF CARE, PLEASE TAKE A FEW MINUTES TO READ AND SIGN OUR OFFICE POLICES

INSURANCE: Prior to your Treatment you will receive a financial agreement. THIS IS ONLY AN ESTIMATE. Your Insurance Company has the right to change to an Alternative benefit for any procedures (White Resin fillings, Crowns, Onlays, Implants & Periodontal Cleanings, etc. without Notification). YOU ARE RESPONSIBLE FOR THE DIFFERENCE AND WILL BE BILLED FOR BALANCE. Please be aware that your dental benefit program is a contract between you, your employer, and the insurance company. We file insurance claims as a courtesy to you and accept payment from your insurance company; provided the deductible and any estimated non-covered fees are paid at each visit.

*****Missed OR Canceling Appointments***:**

We ask that you give our office a minimum of 24 hours in advance to cancel or reschedule any appointment. If a 24 hour notice is not given and you fail to arrive to your appointment, cancel or reschedule less than 24hours from the appointment time the 1st offense is no charge. The 2nd offense is a charge of $150.00 dollars to rebook your appointment. Each missed, rescheduled or canceled appointment after the 2nd offense with less than a 24hour notice is $75.00 each appointment.

We are committed to providing you the Best Dental Care. Our fees reflect our professional commitment to Excellence. Payment in full by cash, credit card, or interest free financing for each appointment as service is Rendered. In the event this Account becomes delinquent and past due, I, agree to pay all costs of collection including, but not limited to interest, court costs, sheriff fees, attorney fees and collection costs as may be necessary.

NOTICE OF PRIVACY PRACTICE & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will Consent to our Use and Disclosure of your Protected Health Information. This gives Broward Dental Associates permission to discuss your treatment with another Doctor or your Insurance Company & to release your Dental Radiographs & Records in the future if you decide to leave our practice. 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 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 may maintain. 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 his Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent and Disclosure form and Notice of Privacy Practices. I understand that, by signing the Consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, referring to Specialists, e-mailing Radiographs, payment activities and health care operations. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting front desk, please just ask for a copy if you would like one. * I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits.**

_____ _____/_____/_____

Signature of Patient (Parent if Minor or Responsible Party) **DATE**

West Broward Dental Associates
Financial responsibility policy

As a result of the many different and confusing insurance company reimbursement policies, it is necessary to have an easily understood financial policy

- **It is important for you to provide the office with any updated insurance information for all carriers with whom you are insured at the time of service. At each visit we need to verify your insurance, please be kind enough to show us your insurance card to ensure that we have the correct carrier on file.**
- **As a service to our patients, we submit your insurance claim for you. Our office will provide the insurance company with all the necessary information to help you receive maximum benefit for your treatment. However, it is the patients' responsibility to know the insurance coverage and benefit. We, at West Broward Dental Associates, will do our best to communicate on your behalf with your insurance carrier.**
- **If a claim is denied, we will research why the rejection occurred and either resubmit to insurance for consultant review or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient or the responsible party and should be paid to us directly. You may contact your insurance carrier for reimbursement.**
- **Insurance is a patients' benefit designed to assist the patient in their financial obligations to our office. The patient is the one receiving the dental service and therefore ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated at West Broward Dental Associates.**
- **The office will estimate the anticipated insurance payment and will collect the estimated balance along with your deductible at the time of service. After the primary insurance payment is received, the patient will be billed for any difference between the estimated balance due and the actual balance due. If the insurance payment is greater than what was anticipated, we will either refund the amount to the patient or leave the credit balance on the patient's account to be applied toward future treatment.**
- **In the event that the person does not have insurance coverage or the patient's insurance company sends payment directly to them, charges for services are due and payable at the time services are rendered, unless a signed financial agreement has been approved.**

Insurance benefits are estimates only. I understand that I am responsible for and co-payments and deductibles, along with any procedures that my insurance company does not cover. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family, or to me during the period of such dental care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the treating dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. I am also responsible for any balance due because of insurance claims not paid within 60 days of services.

_____

Name of Patient (Parent if Minor or Responsible Party)

_____ _____/_____/_____

Signature of Patient (Parent if Minor or Responsible Party) **DATE**