ROOT DENTAL

Your Smile is our Passion

3755 20th Place Vero Beach FL
Office: 772-569-0123 Fax: 772-569-9070
Email: staff@rootdentalvero.com
Website: rootdentalverobeach.com

PATIENT INFORMATION

The following is confidential information and is for our records only

Patient Name: (First) _____ (Last) _____

Address: _____City/State: _____Zip:_____

(PHONE) Home: _____Work: _____Cell: _____

Preferred number: (circle) HOME WORK CELL

E-Mail address: _____

Birth date: _____Age: _____

Driver's License: _____S.S. #: _____

Employer: _____Occupation:_____

Spouse's / Parent's Name: _____Phone: _____

Person to contact in case of emergency: _____Phone: _____

Whom may we thank for referring you to our office?

_____

Did you visit our website after receiving a referral?

_____

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DENTAL INSURANCE CLAIM INFORMATION

Dental insurance is a benefit selected by the patient for which we are not responsible. As a courtesy, we submit claim forms and wait on any estimated reimbursement. The patient, however, is responsible for the entire bill. If information provided is inaccurate, the patient is responsible for full payment to our office.

Insured name: _____ S.S. #:_____

Birth Date: _____

Insurance company name: _____

Employer: _____

Signature_____Date_____

Medical History

Patient Name: _____ Date of Birth: _____

1. **General Practitioner's** Name and Phone #: _____
2. **Cardiologist** or **Orthopedic Doctor's** Name and Phone #: _____
3. Have you ever been **hospitalized or had a major operation**? ☐ Yes ☐ No
   If yes, please explain: _____
4. Have you ever had a **serious head/neck injury**? ☐ Yes ☐ No
   If yes, please explain: _____
5. Are you currently taking any **medications or pills**? ☐ Yes ☐ No
   If yes, please list: _____
6. Do you use **tobacco**? ☐ Yes ☐ No If yes, how much? _____
7. Do you use **controlled substances**? ☐ Yes ☐ No If yes, please list: _____
8. Are you **allergic** to any of the following:
   ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex
   Other_____
9. Have you ever had to **pre-medicate** before dental treatment? Yes No ☐
   _____
10. Have you ever had any **blood clotting** problems? ☐ Yes ☐ No
    _____
11. **WOMEN**- Are you: ☐ Pregnant/Trying to get pregnant ☐ Taking oral contraceptives ☐ Nursing

Do you have/have you had **any of the following**:

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Heart Attack/Failure	☐ Kidney Problems
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Liver Disease
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Heart Pace Maker	☐ Low Blood Pressure
☐ Angina	☐ Diabetes	☐ Heart Trouble/Disease	☐ Lung Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Hemophilia	☐ Mitral Valve Prolapse
☐ Artificial Joints	☐ Easily Winded	☐ Hepatitis A	☐ Pain in Jaw Joints
☐ Asthma	☐ Emphysema	☐ Hepatitis B or C	☐ Radiation Treatments
☐ Blood Disease	☐ Epilepsy/Seizures	☐ Herpes	☐ Renal Dialysis
☐ Breathing Problems	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Stomach Disease
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ Hypoglycemia	☐ Stroke
☐ Cancer	☐ Frequent Cough	☐ Intestinal Disease	
☐ Chemotherapy	☐ Frequent Headaches	☐ Irregular Heartbeat	

Any other **serious illness** not listed above: ☐ Yes ☐ No * if yes, please explain:

_____

Are you taking/have you ever taken **medication for Osteoporosis**? ☐ Yes ☐ No

Dr's Notes:

_____

_____

To the best of my knowledge, I have accurately answered all question on this form, I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Root Dental of any changes in my medical status.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

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FINANCIAL POLICY

At Root Dental, we believe in giving you the best possible dental care. We want you to feel welcome and as comfortable as possible throughout your dental treatment. This includes understanding your treatment plan, as well as our financial policy.

Our policy states that fees are due at the time of service. We do not carry balances on patient accounts. Unpaid balances after 30 days will be charged a 1.5% finance charge per month. Aged accounts can be referred to a collection agency at the discretion of Dr. Root. For your convenience we do accept all major credit cards and offer third party financing. Our financial coordinator would be happy to discuss the details should the need arise for you.

Many people think that if they have dental insurance, it is the insurance company who owes the doctor for his services. This is not the case. The dental insurance contract is between the patient and the insurance company. Therefore, the patient is responsible for the entire bill, regardless of coverage. As a courtesy to our patients, we bill the insurance company and wait on any expected reimbursement however the responsibility will remain with the patient if the estimated reimbursement is not received. Patients are asked to pay their estimated out-of-of-pocket fees at the time of service. If treatment involves major restorative services, we ask patients to pay 50% of the estimated uninsured amount.

We file claims immediately and again in 30 days if we have not received payment. After 60 days, if we have not been paid, we will contact the patient for help in resolving the matter. If after 90 days we are still not paid for the services, a statement is generated to the patient and payment is expected. Any overpayment from the insurance company can be sent to the patient or posted to the account for future work.

An often misunderstood term is *Usual, Customary, and Reasonable Fee Schedule*. This is an arbitrary fee ceiling at which the insurance company will limit reimbursement. After this ceiling, coverage for a particular service will cease. This has nothing to do with the fees our office charges, but with the level of coverage negotiated when the insurance policy was purchased.

This office can make no guarantee of the estimated payment. This office does not absolve the patient of full responsibility for charges in full for treatment rendered. Please sign this form to indicate that you understand and comply with this policy

Signature_____Date_____

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APPOINTMENT CANCELLATION / NO SHOW POLICY

Root Dental appreciates having you as a patient and we are constantly striving to improve our quality and service while keeping our fees as low as possible.

We feel it is courteous to give our office more than 24 hours' notice if a patient must change their appointment. When a patient cancels their appointment at the last minute or simply does not show up for their appointment, we are generally unable to use our time appropriately and as a result we have lost revenue for that day. This is very costly and the cost cannot be recovered!

We have established the following policy for both cancellations without notice and no shows:

First Incident: Root Dental will apply a charge of $50

Second Incident: Root Dental will have the option to apply a Charge of $50 or terminate / dismiss a patient.

Signature_____Date_____

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RECORDS RELEASE FORM

I am requesting that your dental practice release my Protected Health Information to:
(please complete)

Organization Name:	ROOT DENTAL
Patients Name:	
Previous Dentist's Name:	
Previous Dentist's Phone Number:	

If your office has e-mail capabilities, I authorize my records to be sent to ROOT DENTAL by e-mail. Please e-mail to: staff@rootdentalvero.com

Signature_____Date_____

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PATIENT PHOTO RELEASE FORM

I _____hereby authorize Root Dental of Vero Beach, FL or any of their assignees to take photographs, slides, and videos of my teeth jaws, and face. I understand that the photographs, slides, and videos will be used as a record of care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc).

I further understand that if the photographs, slides and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

_____I do not mind if my photographs are used in any of the above stated situations.

_____I only agree to have my teeth shown without any identifying features.

Signature_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of Root Dental's HIPAA Notice of Privacy Practices.

_____ _____
Patient Name (please print) Date

_____
Patient Signature

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):
☐ Parent/Guardian ☐ Power of Attorney ☐ Other: _____

PERSONS AUTHORIZED TO SPEAK ABOUT YOUR TREATMENT OR ACCOUNT:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Please Note: it is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement of receipt of our Notice of Privacy Practices by the individual noted, but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgment
- ☐ A communication barrier prevented us from obtaining acknowledgement
- ☐ The individual was unwilling to sign
- ☐ Other: _____

Staff Member Signature: _____ Date: _____