

# PERSONAL HISTORY

Confidential

**PLEASE PRINT**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State ZipCode

Social Security Number \_\_\_\_\_ Sex M F

Birth Date \_\_\_\_\_ Marital Status S M W D

If minor, name of parent or guardian \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Alternate Phone ( ) \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

***I understand that I am financially responsible for all charges.***

\_\_\_\_\_  
Signature of Patient / Parent or Guardian if minor

## INSURANCE

**Your insurance is a method for you to receive reimbursement for the fees you have paid. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on the contract you have with them, not with our office. It is your responsibility to pay deductible, co-insurance, and any other balances not paid for by your insurance. We will do all we can to assist you in receiving reimbursement, but you are responsible for your bill.**

Dental Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_ Patient's Relationship to Policy Holder \_\_\_\_\_

Policy Holder's Social Security Number \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Policy Holder's Employer / Group Name \_\_\_\_\_ Group # \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

**Your signature is necessary for us to process any insurance claims.  
I hereby authorize payment directly to Dental Specialty Group of Pinellas and named dentist.**

\_\_\_\_\_  
Signature of Patient / Parent or Guardian if minor

\_\_\_\_\_  
Date

## MEDICAL HISTORY

Personal Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

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Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Do you smoke? Y N If yes, how much? \_\_\_\_\_

Do you drink alcohol? Y N If yes, how much? \_\_\_\_\_

Do you have a history of or problems with:

A recent weight change	Y	N	Heart disease	Y	N
Excessive thirst	Y	N	Angina or chest pain	Y	N
Diabetes	Y	N	Liver disease	Y	N
Cuts which have not healed	Y	N	Hepatitis	Y	N
Stroke	Y	N	Anemia	Y	N
Dizzy spells	Y	N	Do you have a bleeding tendency	Y	N
Shortness of breath	Y	N	Excessive bleeding	Y	N
Lung disease	Y	N	High blood pressure	Y	N
Asthma	Y	N	Thyroid disease	Y	N
Bronchitis	Y	N	Tuberculosis	Y	N
Frequent cough	Y	N	Stomach pain	Y	N
Drug abuse	Y	N	Kidney disease or infection	Y	N
AIDS	Y	N	Glaucoma	Y	N
Hay Fever	Y	N	Do you wear contact lenses	Y	N
Sinus problems	Y	N	Seizures	Y	N
Rheumatic Fever or heart murmur	Y	N	Are you pregnant	Y	N
Scarlet Fever	Y	N	Have you donated blood lately	Y	N

How often do you take aspirin? \_\_\_\_\_

Have you ever had I.V. sedation? \_\_\_\_\_

What other serious illnesses or injuries have you had? \_\_\_\_\_ None

What operations or surgeries have you had? \_\_\_\_\_ None

What medicine or pills are you taking now? \_\_\_\_\_ None

What medication(s) are you allergic to? \_\_\_\_\_ None

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**I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE.**

**To the best of my knowledge, all of the preceding answers are true and correct.**

\_\_\_\_\_  
Signature of person completing health history

\_\_\_\_\_  
Date

You will have an opportunity to discuss your health history with the doctor.

\_\_\_\_\_  
DR.'s initials

Dental Specialty Group of Pinellas  
4326 Park Boulevard, Suite C-East  
Pinellas Park, FL 33781  
(727) 544-5345

## **CANCELLATION / MISSED APPOINTMENT POLICY**

**Our office strives to provide optimum treatment and convenience for our patients by offering several specialties in one location. This means however, that each specialist is available only certain days.**

**Therefore, we ask that you help us by keeping your scheduled appointments, and by notifying our office in advance if you are unable to do so.**

**We have a waiting list for appointments and when given advance notice we are often able to accommodate other patients.**

### **ALL PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDULED APPOINTMENTS OR WHO CANCEL WITH LESS THAN 24 HOURS ADVANCE NOTICE WILL BE CHARGED A MISSED APPOINTMENT FEE**

- Missed appointment fees are **NOT** covered by insurance plans and are your responsibility to pay
- If you need to cancel or reschedule an appointment, please give at least **24 hours** notice to avoid a charge
- If you fail your appointment and have not notified the office 24 hours in advance you will be charged a missed appointment fee
- If you miss two consecutive appointments, any remaining appointments scheduled will be cancelled and referring dentist will be notified.

Thank you for your cooperation.

Patient Name (please print): \_\_\_\_\_

Signature below indicates I have read and understand this policy.

Patient(18 or older) or Legal Guardian Signature: \_\_\_\_\_

## INSURANCE BENEFIT ACKNOWLEDGEMENT

Your insurance is a method for you to receive reimbursement for the fees you have paid. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on the contract you have with them, not with our office. It is your responsibility to pay deductible, coinsurance, and any other balances not paid by your insurance company.

In determining the amount of benefits payable, your insurance company may give consideration to an alternate procedure that may accomplish a professional satisfactory result. If an alternate benefit provision is applied to a procedure performed by your dentist and submitted to your insurance company as a claim, the amount of money you owe your dentist may be more than the amount specified on the Explanation of Benefits (EOB).

Estimates of coverage are not a guarantee as eligibility, policy provisions and possible charges from other offices affect payment. Your insurance company may not pay their full estimated portion. **YOU ARE RESPONSIBLE FOR ALL TREATMENT CHARGES NOT PAID BY YOUR INSURANCE COMPANY.**

I agree to pay the fees, including any deductible, co-insurance, and any other balances not paid by my insurance company, to Dental Specialty Group of Pinellas.

\_\_\_\_\_  
Signature of Patient/ Legal Guardian if patient is minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

# Dental Specialty Group of Pinellas

## Acknowledgement of Receipt of Notice of Privacy Practices

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**Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.**

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### **\*\*You May Refuse to Sign This Acknowledgement\*\***

I have been given copy of this office's Notice of Privacy Practices to review and I am aware that the office has a copy of the Notice available to take with me if I request one.

\_\_\_\_\_  
{Please Print Patient's Name}

\_\_\_\_\_  
{Signature of Patient or Legal Guardian}

\_\_\_\_\_  
{Date}

Dental Specialty Group of Pinellas may use or disclose protected health information for the purpose(s) of treatment, payment, collections, or health care operations. We may disclose your personal health care information to other dental and/or medical professionals relating to your treatment, payment, or health care. If you wish to authorize Dental Specialty Group of Pinellas to release your personal health care information to anyone other than for the reasons above, please list below.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

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### For Office Use Only

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We attempted to obtain written proof of Informed Acknowledgement of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_