

SEABREEZE DENTAL GROUP

www.seabreezedentalgroup.com

2520 US 1 South • Saint Augustine, FL 32086

(904)794-4424

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____

Last

First

MI

Preferred Name

Title: _____
Mr/Ms/Mrs/etc

Gender: Male Female

Family Status: Married Single Child Other

Birth Date: _____

SS#: _____

Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City State Zip Code

I prefer to be contacted by

Cell Phone

Text

Email

Home Phone

Leave a message

Whom may we thank for referring you to our practice?

In an emergency, who should be notified? Please enter name, phone number and relationship below

Employer Name

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Responsible Party Information

Please enter information for the person financially responsible for the account

If the patient is the responsible party, please check here, skip this section and continue to the next section.

I am financially responsible for this account.

The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: _____ DL#: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City State Zip Code

Primary Dental Insurance

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Authorization

By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Do you have secondary dental insurance? Yes No

Dental Information

How would you rate the condition of your mouth?

- Excellent Good Fair Poor

Previous Dentist Name and Phone Number

Approximate date of most recent dental exam and/or dental x-rays

I routinely see a dentist every

- 3 mos 4 mos 6 mos 12 mos Not routinely

What is your immediate concern about your dental health?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Had complications from past dental treatment | <input type="checkbox"/> Had trouble getting numb |
| <input type="checkbox"/> Had any reactions to local anesthetic | <input type="checkbox"/> Had/Have braces or orthodontic treatment |
| <input type="checkbox"/> Experiences dry mouth | <input type="checkbox"/> Sensitive to hot, cold, biting, sweets |
| <input type="checkbox"/> Avoid brushing any part of your mouth | <input type="checkbox"/> Food gets trapped between any teeth |
| <input type="checkbox"/> Whitened or bleached your teeth | <input type="checkbox"/> Experienced popping and/or clicking of your jaw joint |
| <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Clenching or grinding of teeth |
| <input type="checkbox"/> Currently or previously wore a bite appliance | <input type="checkbox"/> Gums bleed when brushing or flossing |
| <input type="checkbox"/> Diagnosed and/or treated for gum disease | <input type="checkbox"/> Bone loss around your teeth |
| <input type="checkbox"/> Noticed an unpleasant taste or odor in your mouth | <input type="checkbox"/> Experienced gum recession |
| <input type="checkbox"/> Teeth become loose on their own (without injury) | <input type="checkbox"/> Experienced a burning sensation in your mouth |
| <input type="checkbox"/> Snores or wakes up frequently during the night | |

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

* **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

* **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Name of patient, parent, or guardian completing this form: *

Relationship to patient: *

Response Date: ___/___/___