MIAMI DENTAL COMMUNITY

REGISTRATION

Patient

Name:_____

Address:_____

City_____ZipCode_____

DOB:_____ Gender:_____

SS#:_____ Phone:_____

Email:_____

Emergency Contact:_____

Phone Number:_____

Referred by?_____

Responsible Party

Name:_____

Relation to Patient:_____

Insurance Information

Name of Insured:_____

DOB:_____

SS#_____

Group #:_____

Employer:_____

Insurance Company:_____

Medical History

Heart Problems	Yes/No	AIDS/HIV	Yes/No	Are You Pregnant?	Yes/No
Rheumatic Fever	Yes/No	Do you Smoke?	Yes/No	Allergic to Antibiotics?	Yes/No
Diabetes	Yes/No	Bleeding Problems	Yes/No	If so, please list:_____	
Hepatitis	Yes/No	Epilepsy	Yes/No	_____	
Asthma	Yes/No	Kidney Problems	Yes/No	Other Allergies?	Yes/No
STD	Yes/No	High Blood Pressure	Yes/No	If so, please list:_____	
Anemia	Yes/No	Tuberculosis	Yes/No	_____	
Headaches/Earaches	Yes/No	Ear,Nose and Troat Problems	Yes/No	Osteoporosis	Yes/No

* Any other medical conditions or prescribed medications from the last six months?_____

_____

* Family Physician:_____ Are you under physician's care? Yes/No

* If you are please explain:_____

Dental History

Do your gums bleed while brushing or flossing?	Yes/No	Do you have frequent headache?	Yes/No
Are your teeth sensitive to hot or cold liquid/food?	Yes/No	Do you clench or grind your teeth?	Yes/No
Are your teeh sensitive to sweet or sour liquid/food?	Yes/No	Do you bite your lips frequently?	Yes/No
Do you feel any pain in your teeth?	Yes/No	Have you had orthodontic work?	Yes/No
Do you have sores or lumps in or near your mouth?	Yes/No	Have you had any difficult extractions?	Yes/No
Have you had any head,neck or jaw injuries?	Yes/No	Have you ever had prolonged bleeding	
a) Clicking	Yes/No	following extractions?	Yes/No
b) Pain (joint,ear,side of face)	Yes/No	Have you ever had instructions on the correct method	
c) Difficulty in opening,closing,or chewing	Yes/No	of brushing your teeth or gum care?	Yes/No

Last Dental visit:_____

I understand that the information that I have given(including my medical history) 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.

If this office accepts my dental insurance, I authorize payments directly to this office of any insurance benefits otherwise payable to me, and I assign any and all benefits to this office. I understand that I am responsible for payments of services rendered and responsible for paying any co-payments and deductibles that my insurance does not cover.

Patient/Guardian name:_____

Patient/Guardian signature:_____

Date:_____

HIPPA- PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

* HIPPA - CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD.

I acknowledge that I have been provided with MIAMI DENTAL COMMUNITY ., "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protec Health Information as required and/or permitted by law.

* Confirmo que se me ha proveido con la "Nota de Practicas de Privacidad" de MIAMI DENTAL COMMUNITY., y doy miconsentimiento para usar y compartir informacion Personal De Salud como lo permita y/o requiera la ley.

Patient Name: (please print):

* **Nombre del Paciente**: (por favor en letra de molde):

Patient Signature: (Or legal representative;proof may be requested:

***Firma del Paciente**: (o representante legal; prueba puede ser requerida):

Date:

***Fecha**:

EMAIL/TEXT MESSAGE TO MOBILE PHONE NUMBER CONSENT FORM
*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to optain your concent to communicate with you by email/mobile text messaging regarding your Protected health information **MIAMI DENTAL COMMUNITY., (MDCDS)** offers patients the opportunity to communicate by email/mobile text messaging. Transmiting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/text messaging for these purposes **MDCDS** will use reasonable means to protect the security and confidentiability of email/mobile text messaging information sent and received. However, **MDCDS** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure Purpose: This form is used to optain your concent to communicate with you by email/mobile text messaging regarding your Protected health information

***Proposito**: Esta forma es usada como consentimiento de usted para comunicarnos via correo electronico/mensaje de texto movil en referencia a su informacion de Salud Protegida.**Miami Dental Community.(MDCDS)** ofrece a sus pacientes la oportunidad de comunicacion via correo electronico/mensajes de texto movil. Transmitir informacion via correo electrinico/mensaje de texto movil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propositos. **MDCDS** usara formas razonables de proteger confidencial y seguro la informacion mandada a usted via correo electronico/ mensaje de texto a movil y no sera en ninguna forma responsible si esta informacion confidencial es usada inadvertidamente por otros.

Yo comprendo haber leido y entendido completamente el consentimiento de esta forma.Yo comprendo los riesgos asociados con la comunicacion via correo electronico/mensaje de texto a movil entre **MDCDS** y yo, consiento las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido a sido respondida.

Patient Acknowedgment & Agreement / *Reconocimento y Acuerdo del Paciente

My consented email address is:

*Mi correo electronico autorizado es:

My consented mobile number for text messaging is:

*Mi numero de Movil para mensaje de texto autorizado es:

Patiente Signature:

* Firma del Paciente:

Date:

* Fecha:

IN CASE OF EMERGENCY: Please call 911 or proceed to the nearest emergency room. Do not use this way of communication for that purpose.

***EN CASO DE EMERGENCIA**: Por favor llame al 911 o proceda al centro de emergencia mas cernaco. No use esta forma de comunicacion para eso.

MIAMI DENTAL
COMMUNITY

CONSENT AND AGREEMENT FOR SERVICES

This dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patient understands that if he/she either carries a dental insurance that our office is not contracted with, or do not carry any dental insurance, all dental services furnishes and/or contracted for are going to be charged to patient directly making patient personally responsible for payment on all these dental services. Additionally, if a patient carries dental insurance which does not fully cover the contracted services, the patient will also be responsible for the payment of the difference of the unpaid amount.

Accordingly, I _____, in consideration for the professional services rendered to and/or contracted by me, at my request, agree to pay the cost of such services.

I hereby grant permission to Miami Dental Community and/or its agents and assigns to telephone me in order to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Patient Signature: Date:

MIAMI DENTAL
COMMUNITY

Financial Agreement

Patient agrees to the following payment policy:

Payment is due at the time of service unless prior arrangements have been made.

Payment in full of the estimated patient portion of the fees is due no later than when service/treatment is to be rendered. Patient is always responsible for amounts not covered by insurance, regardless of where the original estimate included an expected insurance benefit, unless prohibited by the law. It is our policy to have a definite agreement between you, the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment, please ask her at the front desk for an approximate cost prior to treatment. For any convenience, we accept cash, checks, all types of credit card and we offer financing through several companies. All emergency dental services performed without previous financial agreement with the office manager must be paid for at the time of service.

PATIENTS NOT COVERED BY DENTAL INSURANCE

Payment is expected when services are rendered. If comprehensive dental work is required, it is understood that at least 90% of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. Any dental service performed without previous financial agreement or verified dental insurance must be paid for at the time of service started.

PATIENTS COVERED BY DENTAL INSURANCE

If you have dental insurance, we will be happy to complete the necessary forms for your claim as a courtesy to you. However, your insurance is a contract between you and your insurance company. You are responsible for your entire bill regardless of what your insurance company pays. We are a third party providing the service to you. We require that you be responsible for your Copayment and deductible at the time of service. After insurance has been filed and **if benefit has not been received within 60 days** from your insurance company, the entire balance becomes the patient's responsibility. A refund will be given when the benefits have been received from the insurance company. The office cannot render services on the assumption your charges will be paid by your insurance company.

Patient or Guardian signature: _____

All balances that have not been paid the estimated portion of their bill at the time of service will incur at $3 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur monthly 1.5% finance charge which equals an 18% per annum rate.

In consideration of the professional service rendered to me or at my request by the doctor, I agree to pay for those services in full. I further agree to pay all costs and reasonable attorneys fee if the suit is instituted here under. If your account is turned over to a collection agency a collection fee of 40% of the account balance will be added and must be paid by the patient. I grant my permission to you to contact me at home or work to discuss matters related to this form. After two consecutive missing appointments, it is our policy not to reschedule you for any further appointments. There is a $25 charge for all returned checks for which the balance of the check and the return check fee will be paid in cash or money order.

We require 24-hour notice to reschedule or cancel an appointment. This will enable us to serve other patients that may need emergency dental care. There is a $35 charge for a missed appointment if notice is not given.

REFUND POLICY

You may discontinue treatment and request a refund from Miami Dental Community at any time. We will refund any amount paid for treatment that you did not receive, except for patients requiring prosthodontic services. Patients requiring prosthodontic services may cancel treatment with no charge prior to natural teeth being prepared or altered for the prosthetic. Once tooth preparation occurs, the patient is liable for the estimated full cost of the services even if he/ she chooses not to complete treatment. All refunds will be processed back to the regional form of payment, except cash payments will be refunded by check.

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. Any charges incurred during this process will be added to the account balance.

By my signature below I authorized Miami Dental Community, to obtain a Consumer Credit Report on me. This authorization is valid for the purpose of verifying information given pursuant to any lawful purpose covered under the Fair Credit Reporting Act. (FCRA) We may use the credit report for any purpose that will be authorized by applicable law in connection with a credit transaction involving you and involving the extension of credit to you or review or collection of your account.

I have read and understand the above financial office policy agreement. I have read and understand the Notice of Privacy Practice (HIPAA) posted in this office and will receive a copy of these upon my request.

SIGNED this _____ day of _____, _____.

Patient/Guardian Name: _____

Patient/guardian Signature: _____