PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name ______________________________ Preferred name ____________ Birth date__________
If minor, parents names ____________________(Circle One Please.) Home/Cell phone __________________
Can we text you an appointment reminder? ❑ yes ❑ no. Work phone ______________
Mailing address ___________________________ City ______________State _______ Zip __________
If seasonal: Summer address _____________________ City ______________State _______ Zip __________
Employer _______________________ Occupation __________________________________
Spouse's name _______________________ Spouse's employer _______________________ ❑ Unmarried
How did you learn about our office? ____________________________________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance
Your Social Security number: ______________ Dental Insurance Co.____________ Group number__________
Covered by spouse's insurance? ❑ yes ❑ no Insurance Co. Phone ______________________________
Spouse's dental insurance company ________________ Group number ____________
Spouse's birthday _______________ Social Security number __________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(PLEASE Circle YES or NO)

Y N Cancer or tumor
Y N Heart ailment or chest pains
Y N Heart murmur, mitral valve prolapse, heart defect
Y N Osteroporosis
Y N Artificial joint or valve
Y N HIGH or LOW blood pressure (circle one)
Y N Pacemaker
Y N Tuberculosis or other lung problems
Y N Kidney disease
Y N Hepatitis or other liver disease
Y N Alcoholism
Y N Blood transfusion
Y N Diabetes
Y N Neurologic condition
Y N Epilepsy, seizures, or fainting spells
Y N Emotional condition
Y N Arthritis
Y N Herpes or cold sores
Y N AIDS or HIV positive
Y N Migraine headaches or frequent headaches
Y N Anemia or blood disorders
Y N Abnormal bleeding after extractions, surgery, or trauma
Y N Hayfever or sinus trouble
Y N Allergies or hives
Y N Asthma
Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:__________________________

Please list medications or supplements you take:

____
____
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____

- ❑ May be pregnant
  Expected delivery date: __________
- ❑ Taking hormones or contraceptives

Name of your physician:____________ **Emergency Contact AND Phone Number**__________________________
Do you have any disease, condition, or problem not listed above?______________________________
____

Please add anything else you would like us to know about:______________________________________

Reason for today's visit: ____

Signature of patient (or parent) ______________________________ Date ____________

Patient Financial Agreement / Acuerdo de financiamiento del paciente

Friendly Dental requires all patients to make financial arrangements with us before we provide treatment. / Friendly Dental requiere que todos los pacientes establezcan un acuerdo financiero antes de suministrarles tratamiento.

1. I understand that full payment is due at the time of service for myself and any party for whom I am financially responsible. / Entiendo que debo efectuar el pago completo en el momento de recibir servicio para mi y cualquier persona de la cual yo sea financieramente responsable.

2. I understand that it is solely my responsibility to confirm which treatments or procedures are covered and/or paid by my insurance (including, but not limited to, any applicable exclusions, deductibles, annual or lifetime maximums). / Entiendo que soy el único responsable de confirmar qué tratamientos o procedimientos están cubiertos y/o pagados por mi seguro (incluyendo pero sin limitarse a cualquier exclusión, deducible, máximo anual o de por vida que aplique).

3. I understand that as a courtesy, Friendly Dental will attempt to verify my insurance coverage from information that I provide and will file two claims per appointment, in accordance with all contracted agreements with the insurance payor(s). Your personal health information (PHI) may be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits. I am required to pay in full, before treatment is performed, the estimated portion of any procedures or treatment that will not be covered by my insurance. / Entiendo que como una cortesía, Friendly Dental intentará verificar mi cobertura de seguro a partir de la información que proporciono y presentará dos reclamaciones por cada cita, de conformidad con todos los acuerdos contraídos con el pagador o pagadores del seguro. Es posible que se utilice su información personal de salud (PHI, por sus siglas en inglés), según sea necesario, para obtener el pago por sus servicios de atención médica. Esto puede incluir determinadas actividades que su plan de seguro de salud puede realizar antes de aprobar o pagar por los servicios de atención médica que le recomendamos, tales como: hacer una determinación de elegibilidad o cobertura para prestaciones de seguro. Entiendo que tengo la obligación de pagar en su totalidad, antes de realizar el tratamiento, la porción estimada de cualquier procedimiento o tratamiento que no estarán cubiertos por mi seguro.

4. I understand that insurance claims will only be filed if I provide Friendly Dental with my social security and insurance identification numbers (if applicable). If I choose not to provide Friendly Dental with my social security number, I understand that I must pay in full for all services rendered. It is Friendly Dental's policy to require social security numbers and a copy of a government-issued picture identification (driver's license) for recordkeeping purposes even though that may not be the policy of my insurance carrier. / Entiendo que puedo hacer una solicitud de reembolso de seguro sólo si le proporciono a Friendly Dental mi número de seguro social y de identificación de seguro (si aplica). Si decido no proporcionar a Friendly Dental mi número de seguro social, entiendo que deberé pagar la totalidad de los servicios prestados. Es la política de Friendly Dental solicitar los números de seguro social y una copia de una identificación con foto emitida por el gobierno (licencia de conducir) para llevar un archivo aunque probablemente no sea la política de mi proveedor de seguros.

5. I understand that although I pay my estimated patient balance on the date of service, the insurance estimate may differ from what my insurance carrier ultimately pays. I will be responsible for any amounts not paid by my insurance for any reason, and I may receive a bill/statement for a balance due which will be immediately payable upon receipt. Credit balances will remain on my account unless I request a refund./ Entiendo que, aunque pague mi balance estimado como paciente en la fecha del servicio, el estimado del seguro puede ser diferente de lo que mi proveedor de seguros pague finalmente. Seré responsable de cualquier cantidad que mi seguro no pague por cualquier razón y probablemente reciba una factura/estado de cuenta por el balance pendiente, el cual deberé pagar inmediatamente en cuanto lo reciba.

6. I understand that all account balances over 30 days will incur an interest charge at the maximum legal rate allowed.* / Entiendo que todas las cuentas con balances que superen 30 días incurrirán un interés a la tasa máxima permitida por la ley.*

7. I understand that I will be charged the maximum service charge allowed by law for any returned check, electronic authorization or any debit sent or provided to Friendly Dental for payment. / Entiendo que se me cobrará el cargo de servicio máximo que permite la ley por cualquier cheque, autorización de pago electrónico o débito enviado o entregado a Friendly Dental que sea rechazado.

8. I understand that I must inform Friendly Dental, in writing, of any concerns, questions or disputes I may have concerning my treatment or charges in a timely manner but not more than 30 days from either the completion of the procedure or awareness of dispute. / Entiendo que debo informar a Friendly Dental, por escrito, cualquier inquietud, pregunta o conflicto que pudiera tener en relación con mi tratamiento o con los cargos de manera oportuna pero no más de 30 días después de completado el procedimiento o del conocimiento del conflicto.

9. I understand that if I fail to pay my account upon it becoming due, Friendly Dental may report my account to credit rating bureaus or to a collection agency and/or take legal action against me for full payment, including but not limited to all related reasonable attorney's fees, collection and/or court costs.* / Entiendo que si no pago mi cuenta en la debida fecha de pago, Friendly Dental puede reportar mi cuenta a las oficinas de crédito, a las agencias de colecciones y/o tomar acción legal contra mí por el pago completo, incluyendo pero no limitado a los honorarios del abogado, los gastos de colección y/o los costos judiciales.

SIGNATURE REQUIRED ON BACK

10. I understand that unless patient records are sent directly to another provider, the charge for copies of x-rays is $18.00 and treatment information is $5.00 or the maximum amount allowed by law or my insurance carrier. These fees are subject to change without notice. / Entiendo que, a menos que se envíe directamente a otro proveedor el expediente del paciente, el cargo por las copias de radiografías es de $18.00 y por las de información sobre el tratamiento es de $5.00 o la cantidad máxima que permita la ley o mi proveedor de seguros. Estas tarifas están sujetas a cambio sin previo aviso.

11. I understand that Friendly Dental currently charges $25.00, or the amount allowed by insurance, for a broken or cancelled appointment unless 24 hours advance notice is given. This fee is subject to change without notice. / Entiendo que Friendly Dental actualmente cobra $25.00 o la cantidad que permita el seguro, por una cita a la que no asista o cancele, a menos que avise con 24 horas de anticipación. Esta tarifa está sujeta a cambio sin previo aviso.

12. I understand that it is my responsibility to immediately notify Friendly Dental of any changes to my address, phone number, work contact information, work status, insurance changes, etc. / Entiendo que tengo la responsabilidad de notificar de inmediato a Friendly Dental sobre cualquier cambio de dirección, numero de teléfono, información de contacto laboral, situación laboral, cambios en el seguro medico, etc.

13. I authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. I further authorize Friendly Dental to deposit checks received on my account when made payable in my name. / Autorizo el pago de los beneficios dentales, que en otras circunstancias se pagarían a mi directamente, a la entidad de servicios dentales que se indica a continuación. También autorizo que Friendly Dental deposite en mi cuenta cheques recibidos que estén en mi nombre.

14. I understand that if I discontinue treatment for a requested procedure, including but not limited to, partials, dentures, crowns, bridgework and surgical preparatory work, I remain responsible for paying all lab related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled for discontinued treatment and I may receive a bill / statement for a balance due. / Entiendo que si interrumpo el tratamiento para un procedimiento solicitado, incluyendo pero no limitándose a, los parciales, las dentaduras, las coronas, la construcción de puente y preparaciones quirúrgicas, yo sigo siendo responsable de pagar todos los costos relacionados con el laboratorio, los materiales y los servicios que fueron incurridos antes de que interrumpiera el tratamiento. Todos los costos relacionados con el tratamiento serán deducidos de cualquier reembolso al cual yo tenga derecho debido a la interrupción del tratamiento y es posible que reciba una factura/estado de cuenta por un saldo pendiente.

15. REFUND OF PRODUCTS: I understand that Friendly Dental's return policy for unopened or unused non-prescription products is thirty (30) days from the date of purchase. Non-prescription products include, but are not limited to, toothbrushes, or other non-prescription merchandise. By law, prescription products cannot be returned which include but are not limited to, whitening products or toothpastes. / DEVOLUCIÓN DE PRODUCTOS: Entiendo que la política de devolución de Friendly Dental para productos de venta sin receta cerrados o no usados es de treinta (30) días a partir de la fecha de compra. Los productos sin receta incluyen, pero no se limitan a cepillos dentales u otra mercadería de venta sin receta. Por ley, los productos de venta con receta no se pueden devolver y, entre estos tenemos, los productos de blanqueamiento o pastas dentales.

I have thoroughly read, understand and agree to the above terms and conditions. / He leído cuidadosamente, entiendo y estoy de acuerdo con los términos y condiciones antedichos.

Printed Name / Nombre con letra de molde ______________________ Date / Fecha ____________

Signature of Patient (or authorized guardian) / Firma del Paciente (o su tutor autorizado) ______________________

If authorized guardian, relationship to patient / Si es el tutor autorizado, relación con el paciente ______________________

16520 S. Tamiami Trl, Ste 106
Fort Myers, FL 33908

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect May 10, 2016 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:	Robin Mamo
Telephone:	239-529-4159
Fax:	239-790-4475
E-Mail:	friendlydentalarts@gmail.com
Address:	16520 S. Tamiami Trl. Ste. 106 Fort Myers, FL 33908

16520 S. Tamiami Trl, Ste 106
Fort Myers, FL 33908

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________ have received a copy of this office's Notice of Privacy Practices.
(PLEASE PRINT NAME)

____
Signature

____
Date

*You May Refuse To Sign This Acknowledgement

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

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Friendly Dental Savings Plan

Where Kindness and Dentistry Meet!

239-529-4159

At Friendly Dental, it is our mission to design healthy and beautiful smiles that last a lifetime. Our number one concern is making sure you have the best possible oral health and appearance, which is a critical factor in your overall health and well-being. We care about our patients and that is why we are making it more affordable while providing the best quality and service. Friendly Dental Savings Plan offers you affordable dental care without the hassles of traditional insurance. This is not an insurance plan.

Great Savings & Benefits

For an affordable annual fee, Friendly Dental Savings Plan provides you with **one free periodic exam, x-ray and cleaning,** in the absence of gum disease, and a **savings of 30 percent** on all other restorative services*. Because Friendly Dental Savings Plan is a discount dental plan, it offers you the same great benefits as a traditional insurance plan with even greater simplicity and flexibility, including:

- No claim forms
- No deductibles
- No hidden charges
- No pre-authorization forms
- No limits or pre-existing conditions
- No waiting period – receive immediate benefits

Annual Enrollment Fee

Membership Plan	Annual Fee
Individual	$100 per year
Each Additional Person (Spouses and dependent children)	$75 per year

The patient has the right to refuse to pay, cancel payment or be reimbursed for a payment. The patient and any other person responsible for payment has the right for any other service, examination, or treatment which is performed as a result of and within 72 hours of responding to the advertisement for the free, discounted fee, or reduced fee service, examination, or treatment, additional charges may be incurred for related services, which may be required in individual cases. Additional charges may be incurred for related services which may be required in individual cases. DN#20600

Exclusions

The following services are not covered or offered by Friendly Dental PA

- Oral Surgery requiring the setting of fractures or dislocations.
- Any Treatment, which cannot be performed because of the general health and physical limits of the eligible Member, as indicated by said Member's personal physician, or participating Friendly Dental dentist/specialist.
- Dispensing of drugs.
- Any treatment paid for by Worker's Compensation or employer's liability laws, by a federal or state government agency or other insurance coverage carried by the Member.
- Any treatment provided without cost by any municipality, county or other political subdivision.
- The administration of general anesthesia.
- Any dental care provided by a specialist outside the office of Friendly Dental.
- Services resulting from any act of war, declared or not, or resulting from military services.
- The participating dentist shall have the right to refuse treatment to a Member who fails to follow a prescribed course of treatment.
- All related fees for admission, use, or stays in a hospital, outpatient surgery center or other similar care facility.
- Any procedure that in the professional opinion of the participating dentist or specialist
  -has poor probability for success based on the condition of the tooth or teeth or surrounding structures.
  -is inconsistent with generally accepted standards for dentistry.
- Consultations for non-covered benefits.
- Accidental injury defined as damage to the hard and soft tissue of the oral cavity resulting from forces external to the mouth.

Limitations

- Full mouth or panoramic x-rays once every 3 years.
- A Prophylaxis (routine cleaning) cannot be performed on a Member with untreated periodontal disease.
- Replacement of complete and partial dentures once every 5 years.
- Replacement of crowns once every 5 years.
- Replacement of fixed bridges once every 5 years.
- Sealants are covered only on permanent posterior teeth, one per tooth every 3 years.
- Endodontic treatment is not covered on permanent teeth that have had a pulpotomy performed in the previous 6 months.

***Not valid with any other offers, promotions or dental insurance.**

Patient Signature: ______________________ Date: __________

Patient Name (Please Print): ______________________

Additional Family Member(s)______________________

Revised 7/28/2017