Consent for Services

ORANGE PARK Smiles
DOUGLAS M. REED D.D.S.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost of incurred in their care and 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 or credit at the time services are performed.

Patents who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patent's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A late charge of #20.00 or 1 ½ % per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fees estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or with in five (5) days of billing of credit shall be extended. I further agree that the reasonable value of said service shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of reasonable attorney fees or collections fees if suit be instituted hereunder.

I understand that I may be charged for any appointments that are cancelled or changed on my behalf within 24 hours of its original appointed date.

I grant my permission to you or assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____
Signature of Patient, Parent or Guardian

_____ Date: _____ Relationship to Patient: _____
Signature of Guarantor of Payment / Responsible person

Contact Form

How do you want to be contacted for confirming your appointments?
Please check the way you want to be contact and enter your contact information.

☐ Email: _____

☐ Texting (cell phone number): (_____) - _____- _____

☐ Standard Call (phone number): (_____) - _____- _____

This number is my: ☐Cell phone. ☐Home phone, ☐Work phone

HEALTH HISTORY

Date _____ **Patient Name** _____ **Name you wish to be called** _____
Physical Address _____ **Home Phone** _____
City _____ **State** _____ **Zip Code** _____ **Work Phone** _____
Mailing Address _____ **Cell Phone** _____
City _____ **State** _____ **Zip Code** _____
Best Time and Place to Reach You Live and In Person _____
Sex: □ **M** □ **F** **Age** _____ **Birthdate** _____ □ **Single** □ **Married** □ **Widowed** □ **Separated** □ **Divorced**
Patient SS # _____ **Occupation** _____ **Employer** _____
Employer Address _____ **Employer Phone** _____
Spouse Name _____ **Birthdate** _____ **SS#** _____
Occupation _____ **Spouse's Employer** _____

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name _____ **Relationship to you** _____□
Address and Phone Number of Emergency Contact Person _____
Whom may we thank for referring you? _____
Who is responsible for this account? _____ **Relationship to patient** _____

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Insurance Company _____ **Group #** _____
Is patient covered by additional insurance? □ **yes** □ **no Subscriber's name** _____
Subscriber's Birthdate _____ **Subscriber's SS#** _____ **Relationship to Patient** _____
Insurance company _____ **Group #** _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ **and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

_____ _____ _____
Responsible Party Signature **Relationship** **Date**

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DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ **City/State** _____
Date of last dental visit _____ **Date of last dental X-rays** _____
Please check Yes or No to indicate if you have had any of the following:

Bad breath	□ **Yes** □ **No**	**Bleeding gums**	□ **Yes** □ **No**	**Blisters on lips or mouth**	□ **Yes** □ **No**
Burning sensation on tongue	□ **Yes** □ **No**	**Chew on one side of mouth**	□ **Yes** □ **No**	**Cigarette, pipe or cigar smoking**	□ **Yes** □ **No**
Clicking or popping Jaw	□ **Yes** □ **No**	**Dry mouth**	□ **Yes** □ **No**	**Fingernail biting**	□ **Yes** □ **No**
Do you or have you ever experienced pain/discomfort in your jaw joint	□ **Yes** □ **No**	**Food collection between teeth**		**Chewing tobacco**	□ **Yes** □ **No**
Food collection tender	□ **Yes** □ **No**	**Foreign objects**	□ **Yes** □ **No**	**Grinding teeth**	□ **Yes** □ **No**
Periodontal	□ **Yes** □ **No**	**Jaw pain or tiredness**	□ **Yes** □ **No**	**Lip or cheek biting**	□ **Yes** □ **No**
Loose teeth or broken fillings	□ **Yes** □ **No**	**Mouth breathing**	□ **Yes** □ **No**	**Orthodontic treatment**	□ **Yes** □ **No**
Pain around ear	□ **Yes** □ **No**	**Sensitivity to cold treatment**	□ **Yes** □ **No**	**Gums swollen or**	□ **Yes** □ **No**
Sensitivity to heat	□ **Yes** □ **No**	**Sensitivity to sweets**	□ **Yes** □ **No**	**Sensitivity when biting**	□ **Yes** □ **No**
Sores or growths in your mouth	□ **Yes** □ **No**	**How often do you floss** _____		**Do you like your smile**	□ **Yes** □ **No**
		How often do you brush?_____		**Type of bristles**	□**Hard** □**Medium** □**Soft**
				Have you ever had a serious or difficult problem associated with previous dental work	□ **Yes** □ **No**

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MEDICAL HISTORY

Physician's Name _____ **Date of last visit** _____

Please check yes or no to indicate if you have had any of the following:

AIDS	□ Yes □ No	**Epilepsy**	□ Yes □ No	**Psychiatric Care**	□ Yes □ No
Anemia	□ Yes □ No	**Fainting or dizziness**	□ Yes □ No	**Radiation Treatment**	□ Yes □ No
Arthritis, Rheumatism	□ Yes □ No	**Glaucoma**	□ Yes □ No	**Respiratory Disease**	□ Yes □ No
		Headaches	□ Yes □ No	**Rheumatic Fever**	□ Yes □ No
Artificial heart valves	□ Yes □ No	**Heart Murmur**	□ Yes □ No	**Scarlet Fever**	□ Yes □ No
		Heart Problems	□ Yes □ No	**Shortness of Breath**	□ Yes □ No
Artificial Joints	□ Yes □ No	**Hepatitis**	□ Yes □ No	**Sinus Trouble**	□ Yes □ No
Asthma	□ Yes □ No	**Type** _____		**Skin Rash**	□ Yes □ No
Back Problems	□ Yes □ No	**Herpes**	□ Yes □ No	**Special Diet**	□ Yes □ No
Bleeding abnormally (with extractions or surgery)	□ Yes □ No	**High Blood Pressure**	□ Yes □ No	**Stroke**	□ Yes □ No
		Meds: _____		**Swelling of Feet or ankles**	□ Yes □ No
	□ Yes □ No	**HIV Positive**	□ Yes □ No		
Blood Disease	□ Yes □ No	**Jaundice**	□ Yes □ No	**Swollen Neck Glands**	□ Yes □ No
Cancer	□ Yes □ No	**Jaw Pain**	□ Yes □ No	**Thyroid Problems**	□ Yes □ No
Chemical dependency	□ Yes □ No	**Joint replacement**	□ Yes □ No	**Tonsillitis**	□ Yes □ No
Chemotherapy	□ Yes □ No	**Kidney Disease**	□ Yes □ No	**Tuberculosis**	□ Yes □ No
Circulatory problems	□ Yes □ No	**Liver Disease**	□ Yes □ No	**Tumor or growth on Head or Neck**	□ Yes □ No
		Low Blood Pressure	□ Yes □ No		
Congenital Heart Lesions	□ Yes □ No	**Mitral Valve Prolapse**	□ Yes □ No	**Ulcer**	□ Yes □ No
		Nervous Problems	□ Yes □ No	**Venereal Disease**	□ Yes □ No
Cortisone treatments	□ Yes □ No	**Pacemaker**	□ Yes □ No	**Weight Loss, unexplained**	□ Yes □ No
		Women:			
Cough, Persistent or bloody	□ Yes □ No	**Are you pregnant?**	□ Yes □ No	**Any hospital stays**	□ Yes □ No
		Due date _____		**Explain** _____	
Diabetes	□ Yes □ No	**Are you nursing?**	□ Yes □ No	_____	
Do you wear Contact lenses	□ Yes □ No	**Are you taking birth control pills?**	□ Yes □ No	_____	
				_____	

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MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

- □ **Aspirin**
- □ **Barbiturates (sleeping pills)**
- □ **Codeine**
- □ **Iodine**
- □ **Latex**
- □ **Local Anesthetic**
- □ **Penicillin**
- □ **Sulfa**
- □ **Other** _____

_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Our office is required by law, to maintain the privacy and confidentially of your protected health information and to provide our patients with notice of our legal privacy practices with respect to your protected health information.

Treatment
We may disclose your health care information to other health care professionals outside of our practice for the purpose of treatment, payment, or health care operations. For example, if we refer you to a specialist reguarding your condition, in the instance that Dr. Reed is out of town and another dental practitioner is covering, or in the event of a medical emergency.

Payment
We may disclose your health information to your insurance company in an effort to get payment for the services provided to you or services needed in reference to your dental health. As a courtesy to our patients we submit itemized billing statements to your insurance carrier and in some cases the insurance company requires supporting information such as diagnosis, procedure dates, and conditions of prior care.

Workers' Compensation
We may disclose your health information as necessary to comply with the State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for you care, about your medical condition or in the event of an emergency or your death.

Please list who you want contacted in the event of an emergency other than 911:

_____ _____
Name **Phone Number**

Public Health
As required by law, we may disclose your health information to public health authorities in reference to disease control and prevention, injury or disability, abuse or neglect, use of medications and reactions to medications, and infection exposure.

I, ***(Print Name)*** _____ have had an opportunity to read and consider the contents of this office's privacy practices. I understand that by signing this consent form, I am giving my consent to Douglas Reed, D.D.S. and his staff to disclose my health care information as described above.

Signature (of Adult Patient or Responsible Adult for Patient under 18 years of age)

X_____

_____ _____
Print Signed Name **Date**

Please list **anyone else** with which you approve of us sharing your health care information:

_____ _____
Name **Phone Number**

_____ _____
Name **Phone Number**