7599 Park Blvd N, Suite #200 | Pinellas Park, FL 33781 | 727-999-2075 | www.sandbaydental.com

Patient Registration

Name: _____ Title: _____

Preferred Name: _____ Gender: _____ Family Status: Married, Single, Child

DOB: _____ SS#: _____ Email Address: _____

Home P: _____ Work: _____ Cell:_____ Best # to call: _____

Address: _____City:_____State:_____ Zip:_____

Employer Name: _____ Phone: _____

Address: _____City:_____State:_____ Zip:_____

Occupation: _____

Physician: _____

Phone #: _____

Personal Responsible for Account if Minor

Name of Parent/Guardian: _____

Parent/Guardian's SS#: _____

Parent/Guardian's Birth date: _____

Parent/Guardian's Employer:_____

Employer's Address: _____

_____

Dental Insurance Information

Insured's Name:_____

DOB: _____ SS#: _____

Relationship to pt: _____

Insured's Employer:_____

Ins. Co. Name: _____

Ins. Co. Address: _____

_____

Phone#: _____

ID#: _____

Group#: _____

Who may we thank for referring you to our office?

_____

What would you like to accomplish with today's visit? _____

Previous Dentist: _____

How long since your last dental visit? _____

Health History

Indicate which of the following you have or have had by circling **Yes** or **No**.

Pre-Med Amox	Y	N	Pre-Med-Clind	Y	N	Pre-Med Other	Y	N
Allergies	Y	N	Allergy-Aspirin	Y	N	Allergy-Codeine	Y	N
Allergy-Erythro	Y	N	Allergy-Hay Fever	Y	N	Allergy-Latex	Y	N
Allergy-Other	Y	N	Allergy-Penicillin	Y	N	Allergy-Sulfa	Y	N
Anemia	Y	N	Arthritis	Y	N	Bisphosphonates	Y	N
Artificial Joints	Y	N	Asthma/Emphysema	Y	N	Cancer	Y	N
Blood Disease	Y	N	Blood Thinners	Y	N	Dizziness	Y	N
Chemotherapy Tx	Y	N	Diabetes	Y	N	Excessive Bleeding	Y	N
Drug Addiction	Y	N	Epilepsy/Seizures	Y	N	Fever Blisters	Y	N
Fainting	Y	N	Glaucoma	Y	N	Head Injuries	Y	N
Heart Disease	Y	N	Heart Murmur	Y	N	Heart/Valve Surgery	Y	N
Hepatitis	Y	N	High Blood Pressure	Y	N	HIV	Y	N
Jaundice	Y	N	Kidney Disease	Y	N	Liver Disease	Y	N
Lupus	Y	N	Mental Disorders	Y	N	Nervous Disorders	Y	N
Other	Y	N	Pacemaker	Y	N	Radiation Treatment	Y	N
Respiratory Problems	Y	N	Rheumatic Fever	Y	N	Rheumatism	Y	N
Sinus Problems	Y	N	Stomach Problems	Y	N	Stroke	Y	N
Thyroid	Y	N	TMJ	Y	N	Tobacco Products	Y	N
Tuberculosis	Y	N	Tumors	Y	N	Ulcers	Y	N

Are you pregnant? Y N If yes, what month? _____ Are you nursing? Y N

List ALL medications and herbal supplements: _____

_____

Have you been given or have you taken any of the following medications: Please circle

Fosamax (Alendronate) Acetonel/Atelvia (Risedronate) Boniva (Ibandronate)

Bonefos/Clasteon (Clodronate) Aredia (Pamidronate) Reclast/Zometa (Zoledronic Acid)

Do you have any heart conditions or joint replacements that require premedication? _____

Any other conditions we should aware of? _____

We understand that a situation may arise that could force you to postpone your treatment. Please understand that such changes affect not only your dentist but our ability to help other patients. Doctor's time as well as that of our staff, is a precious commodity and we request our courtesy and respect. A $50 administrative fee will be charged to patients who habitually change or cancel their appointments within 48 hours of their scheduled visit.
I understand that all responsibility for payment of dental services provide in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I further understand that a collection fees may be added to overdue balances.
I authorize release of any information for insurance, medical or dental purposes.
I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

Signature: _____ Date: _____
Patient/Guardian

Signature: _____ Date: _____
Doctor

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Fax: (72) 999-2074

Patient Bill of Rights

At SandBay Dental, we take pride in how we treat our patients and the quality of our work. Our mission of caring directs everything in our office including our commitment to participating in advanced training in major areas so we can provide a full range of treatment, including periodontal, preventative, restorative and cosmetic dentistry.

Patient's Rights

1. The patient has the right to the appropriate care SandBay Dental can provide for their problem, without regard to race, sex, national origin, color, religion, age or disability.

2. The patient has the right to be treated kindly and respectfully by all personnel; to be addressed by their proper name and without undue familiarity; and to be assured that their individual will be respected.

3. The patient has the right to know which members of the health care team (dental student, dental hygiene student, graduate dentist and/or faculty member) are directly responsible for their care, including their names.

4. The patient has the right to ask their dental student and other members of the health care team questions and to receive answers from them concerning their dental condition, treatment and plans for care.

5. The patient has the right to discuss any treatment, procedure, or operation planned for them with members of the health care team, so that the patient may understand the purpose, probably results and/or alternatives and risks involved before consenting to the agreed upon treatment plan.

6. The patient has the right to know what we feel is the optimal treatment plan for them as well as the right to ask us to scale down the optimal plan to fit within their financial or time constraints, if possible.

7. The patient has the right to receive an estimate of the cost of dental treatment and to be informed of changes in the total cost, if changes in their treatment plan occur.

8. The patient has the right to withdraw consent as long as the medical intervention has not yet been applied.

Patient Signature: _____ Date: _____

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BROKEN APPOINTMENT FORM

Our office values your time and takes great effort to stay on schedule to see you at the time of your scheduled appointment. We feel our time is just as valuable so we request a 24 hour notice for all cancelled appointments.

We know that sometimes unforeseen situations arise so as a courtesy to our patients we do allow one unexpected cancellation without notice. After this we will exercise our right to charge for any additional cancellations without a 24 hour prior notice.

If we do not receive a 24 hour cancellation notice for your scheduled hygiene appointment we will charge a $25.00 cancellation fee. _____
Initials

If we do not receive a 24 hour cancellation notice for your scheduled doctor's appointment we will charge a $50.00 cancellation fee. _____
Initials

We will continue to use all efforts to confirm your appointments by phone, text and email.

We appreciate your cooperation and understanding.

_____ _____
Signature of Patient or Guarantor Date

_____ _____
Date Reason for Missed Appointment

_____ _____
Date Reason for Missed Appointment

_____ _____
Date Reason for Missed Appointment

OUR FINANCIAL INFORMATION

- Please understand that payment of your bill is considered part of your treatment.
- Payment is due at the time service is provided. Our office accepts **cash, personal checks, MasterCard, Visa**, and **Discover**. Outside financing is available upon request and approval.
- **Please check if you would like more information about financing options**.
- **Please Note**: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal services, you will be responsible for any collection and/or legal charges incurred up to 35%.

Do you Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim. We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or your financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Consent: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Patient Signature (Parent of Child): _____ Date: _____

"Better health now & wellness for life"

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NOTICE OF PRIVACY- WRITTEN PERMISSION

There's been a development in the health industry that requires us to get your written permission in case we ever need to share your treatment information with a specialist, dental lab, or an insurance company. When you sign this form, you give us your approval to share your treatment information and you acknowledgement that you are aware of our potential need to do so.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices. I also give my permission should it be necessary to share my treatment information. A copy of this notice and acknowledgement will be kept in my Patient file.
You may refuse to sign this acknowledgement. However, without your signature, we cannot file your insurance or treat you today.

Please Print Name:
Patient Signature:
Date:

For Office Use Only (Patients should not write below this line):

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 obtained acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)