Windermere Center for Dentistry

401 Main St. Ste A
Windermere, Fl 34786
(407)909-1097

Patient Information

Patient Name ________________________ **Preferred Name** ________________________

Phone (Home) ________________________ **Date of Birth** ________________________

Phone (Work) ________________________ **Email Address** ________________________

Phone (Cell) ________________________ **Sex: Male ☐ Female ☐ Marital Status** ___________

Home Address ________________________ **City/State/Zip** ________________________

Emergency Contact Information:

Name ____________________ **Relationship** ____________________ **Phone** ____________________

Name of Primary Care Physician ________________________ **Phone** ____________________

Please list other members of your immediate family who are patients in our office: ________________________

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Referring Information:

Who can we thank for referring you? **Or did you find us on your own?**

Family Member: ________________________ **Our Website** ☐ **Other** ____________

Coworker: ________________________ **Southwest Bulletin** ☐

Friend: ________________________ **Insurance Provider** ☐

Doctor: ________________________ **Yellow Pages** ☐

Dental Insurance Information:

Name of Guarantor/Insured ____________________ **Relationship to Guarantor** ____________________

Guarantor's Date of Birth ____________________ **Guarantor's Social Security #** ____________________

Guarantor's Employer ____________________ **Guarantor's ID #** ____________________

Insurance Company____________________ **Insurance Company's Phone #** ____________________

Date of last dental cleaning ___________________________ Do you suffer from dental anxiety? Yes ☐ No ☐

Have you ever had any complications or allergic reactions following dental treatment? Yes ☐ No ☐

If yes explain: ____

Are you under a physician's care now? Yes ☐ No ☐ ____

Have you ever been hospitalized or had any major operations? Yes ☐ No ☐ ____________________________

Have you ever had a serious head or neck injury? Yes ☐ No ☐ ____________________________

Are you on a special diet? Yes ☐ No ☐ _________________________ How long? ________________________

Do you use tobacco products? Yes ☐ No ☐ _________________________ How long? ________________________

Do you use a controlled substance? Yes ☐ No ☐ ____

If you could change anything about your teeth, what would it be? ____

Are you aware of clenching or grinding your teeth? ____

Do you wake up with a headache? ____

Do you wake up with jaw or neck pain? ____

Are you aware of snoring when you sleep? ____

Why did you leave your previous dentist? ____

Female Patients-are you: ☐ Nursing? ☐ Taking oral contraceptives? ☐ Pregnant/Trying to get pregnant? Due date ________

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Local Anesthetics ☐ Nickel ☐ Sulfa ☐ Other ____

Do you have, or have had, any of the following?

☐ AIDS/ HIV Positive
☐ Alzheimer's disease
☐ Anaphylaxis
☐ Anemia
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemical Dependencies
☐ Chemotherapy
☐ Chest Pains
☐ Cholesterol-High/Low
☐ Cold Sores/ Fever Blisters
☐ Congenital Heart Disorder
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/ Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/ Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble/ Disease
☐ Hemophilia
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Prolonged Bleeding
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Rheumatoid Arthritis
☐ Scarlet Fever
☐ Scoliosis
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/ Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Transplant/Prosthesis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease

If yes to any of the above please explain. ____

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Have you ever had any serious illness not listed above? Yes ☐ No ☐ If Yes, please explain: ___________________________

____

List any medications you are currently taking (include over-the-counter drugs or vitamins): ___________________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian ____________________________ Relationship _______________ Date ________________

HIPPA Acknowledgement & Authorization

I hereby authorize my insurance company or any other third party payer to pay directly to Windermere Center for Dentistry all charges submitted for services incurred by me. I understand that I will be responsible for any and all charges not paid by my insurance company or third party payer. I authorize Windermere Center for Dentistry to release information concerning my dental/medical condition to my insurance company, employer, attorney or multiple health care providers who may be involved in the treatment directly or indirectly. I assign payment directly to the doctors at Windermere Center for Dentistry which may cover in whole or part of the dental services that I have received. The authorization shall be valid until I notify Windermere Center for Dentistry in writing of a cancellation. A photo copy of the authorization shall be as valid as the original copy.

I hereby acknowledge that I have read the HIPPA Privacy Policy and understand my rights contained in the notice. By way of my signature, I provide Windermere Center for Dentistry with my authorization and consent to use and disclose my protected dental/health care information for the purposes of treatment, payment and health care operations as described in the HIPPA Privacy Policy.

Signature of patient, parent or guardian ____________________________ Relationship _______________ Date ________________

Office Policy

Effective September 1, 2009 there will be a $50 fee per hour scheduled for same day or short notice cancellations and missed appointments. There is no charge for cancellations that are made at least 24 business hours before the day of the scheduled appointment. Our normal business hours are Mondays & Wednesdays 9am-6pm and Tuesdays & Thursdays 8am-5pm. Our office is closed on Fridays. Messages left via voicemail will NOT be counted as an official cancellation notice. THESE FEES ARE NOT COVERED BY INSURANCE CARRIERS; IT WILL BE THE FAMILY'S RESPONSIBILITY TO PAY. Payment in full is required before any future appointments can be made. Patients with a chronic history of failed or broken appointments will have to call the day of to see if times are available since our office will no longer be able to reserve appointments in advance.

Signature of patient, parent or guardian ____________________________ Relationship _______________ Date ________________

Insurance

In order to meet the need of our patients, we have enrolled in various insurance programs. As you can imagine, keeping up with all of the individual requirements for each of the insurance companies can be practically impossible. Each program may have different requirements or stipulations that dictate which services can be provided and how often they can be provided. These rules can vary even in the same company with various programs being offered. At Windermere Center for Dentistry, providing the highest quality in dental car to our patients in an atmosphere of genuine caring is our primary concern. It is possible that your insurance provider may NOT cover every service we provide in our office, and in these cases, we will have no choice but to bill you for the services provided. It is not our sole responsibility to know every detail of your particular insurance policy so if we work together, both doing our parts to familiarize ourselves with your specific policy, we can focus on what we do best-take care of you.

I understand that my insurance company may disallow and not pay fees related to certain procedures and services that I may receive at this office. If these are disallowed, I understand that I am responsible for payment. I understand that I am also responsible for any balance that is not paid by my insurance company after 30 days.

Signature of patient, parent or guardian ____________________________ Relationship _______________ Date ________________