

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: _____

Referring Information:

Who can we thank for referring you?

Family Member: _____

Coworker: _____

Friend: _____

Doctor: _____

Or did you find us on your own?

Our Website Other _____

Southwest Bulletin

Insurance Provider

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?

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

If yes to any of the above please explain. _____

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): _____

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 care 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 _____