# Dental Specialists of North Florida
## New Patient Registration Form

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Other: _____

**Patient Information**

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Birth Date: _____ Age: ____ Soc Sec: _____

Occupation: _____ Place of Employment: _____

E-Mail: _____ Preferred Method of Contact: ☐ Email ☐ Text ☐ Phone

Emergency Contact:

First Name_____ Last Name: _____ Phone: _____

Address: _____

Have you been a patient in any of our offices before? ☐ Yes ☐ No Have any of your family members?_____

Who may we thank for referring you to our office?_____

**Primary Insurance Information**

Policy Holder: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policy Holder Soc. Sec/ID #: _____ Policy Holder Birth Date: _____

Employer: _____ Ins. Company: _____

**Secondary Insurance Information**

Policy Holder: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Policy Holder Soc. Sec/ID #: _____ Policy Holder Birth Date: _____

Employer: _____ Ins. Company: _____

**Responsible Party** (if other than patient)

First Name: _____ Last Name: _____

Address: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Driver's Lic: _____

Occupation: _____ Place of Employment: _____

Patient's Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

## MEDICAL HISTORY

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following? Do you pre-medicate before dental appointments? _____

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Chest Pains | ☐ Heart Attack/Failure | ☐ Recent Weight Loss |
| ☐ Alzheimer's Disease | ☐ Cold Sores/Fever Blisters | ☐ Heart Murmur | ☐ Renal Dialysis |
| ☐ Allergic Reactions | ☐ Congenital Heart Disorder | ☐ Heart Pace Maker | ☐ Sinus Trouble |
| ☐ Anemia | ☐ Steroid Medicine | ☐ Heart Trouble/Disease | ☐ Stomach/Intestinal Disease |
| ☐ Angina | ☐ Diabetes | ☐ Hemophilia | ☐ Stroke |
| ☐ Arthritis/Gout | ☐ Drug Addiction | ☐ Hepatitis A | ☐ Swelling of Limbs |
| ☐ Artificial Heart Valve | ☐ Easily Winded | ☐ Hepatitis B, C | ☐ Thyroid Disease |
| ☐ Artifical Joint | ☐ Emphysema/COPD | ☐ Hypoglycemia | ☐ Tumors or Growths |
| ☐ Asthma | ☐ Epilepsy or Seizures | ☐ Irregular Heartbeat | ☐ Stomach Ulcers |
| ☐ Blood Disease | ☐ Excessive Bleeding | ☐ Kidney Problems | ☐ Radiation Treatments |
| ☐ Breathing Problems | ☐ Excessive Thirst | ☐ Liver Disease | |
| ☐ Bruise Easily | ☐ Fainting Spells/Dizziness | ☐ Blood Pressure Problems | |
| ☐ Cancer | ☐ Frequent Cough | ☐ Lung Disease | |
| ☐ Chemotherapy | ☐ Glaucoma | ☐ Psychiatric Care | |

Have you ever had any illness not listed above? ☐ Yes ☐ No ☐ N/A _____

Are you under a physician's care now? ☐ Yes ☐ No ☐ N/A Name of Doctor or Specialist _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ☐ N/A _____

Have you ever had a serious neck or head injury? ☐ Yes ☐ No ☐ N/A _____

Are you taking any medications, pills, or drugs or over the counter vitamins/supplements? ☐ Yes ☐ No ☐ N/A

Please list:

_____

_____

_____

Are you or have you ever taken Bisphosphonate medications, such as Fosamax, Boniva, Reclast, Zometa or other? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No (Please specify cigarettes, cigars, chewing tobacco, other) _____

Do you use recreational drugs? ☐ Yes ☐ No (Please specify for example: Marijuana, Cocaine, Methamphetamines or other) _____

Do you use controlled substances? ☐ Yes ☐ No ☐ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives

## DENTAL HISTORY

Family dentist _____ Preferred pharmacy _____

What is your primary reason for your visit today? _____

| | | |
|---|---|---|
| Are you having pain or discomfort at this time? | ☐ Yes | ☐ No |
| Do your gums bleed? | ☐ Yes | ☐ No |
| Have you had prior periodontal therapy or treatment for gum disease? | ☐ Yes | ☐ No |
| Have you had orthodontic therapy (braces)? | ☐ Yes | ☐ No |
| Are you satisfied with the appearance of your teeth? | ☐ Yes | ☐ No |
| Do you feel nervous about having dental treatment? | ☐ Yes | ☐ No |
| Have you ever had a "bad experience" in a dental office? | ☐ Yes | ☐ No |
| Would you like to consider options for sedation during dental treatment? | ☐ Yes | ☐ No |

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 employment, or insurance status.

_____

SIGNATURE OF PATIENT, PARENT or GUARDIAN DATE

DENTAL SPECIALISTS
OF NORTH FLORIDA
PERIODONTICS | IMPLANT SURGERY

I have read "Notice of Privacy Practices" for Dental Specialists of North Florida. I have been given a paper copy for my records if I've requested it.
Insurance card must be present at the time of my initial visit.
Copy of Driver's License or Photo ID is required
Insurance has been estimated and is not a guarantee of payment by your insurance company
Any balance incurred as a result of not having the correct insurance information, will be the patient responsibility. We cannot file insurance without the correct information
Self pay patients are required to pay in full at the time of their appointment, unless prior arrangements have been made before treatment has been started.
We file primary insurance only
If your insurance pays more than your balance, the Dr. will send you a refund. If your insurance pays less than your balance, you will be sent a statement.
You are responsible for any charges your insurance does not pay.
If for any reason your account is turned over to a collection agency, a 30% collection fee will be added to your account.
24 hour advance notice is required for cancellations

Parent/Guardian Signature _____ Date _____

John Thousand IV DDS MSD | Robert Thousand Jr. DDS | Oral-Health Enthusiasts
St. Augustine: 10 St Johns Medical Park Dr, Ste C St Augustine, FL 32086 | P: (904) 794 1000 | F: (904) 794 1004
Palm Coast: 3 Cypress Branch Way, Ste 107 Palm Coast, FL 32164 | P: (386) 986 1000 | F: (386) 446 1033
www.DSNFPerio.com | DSNFOffice@gmail.com

DENTAL SPECIALISTS
OF NORTH FLORIDA
PERIODONTICS | IMPLANT SURGERY

Patient Name_____

Appointment Date _____

Below is an explanation of the fees for your Periodontal appointment. Our office policy is **payment due upon services rendered,** which includes co-pays and deductibles. As a courtesy to you, we will file your dental insurance. Any insurance coverage is estimated. You, the patient, are responsible for all fees, regardless of insurance coverage. If we are not a preferred provider for your insurance company we require 50% of the cost at the time of service, to ensure the difference between fee schedules, co-pays and deductibles is covered. There are some insurance companies that do not allow payment to be made to a non provider; they only pay the insured. In this case, you the patient, are responsible for 100% of the fees. Any balance incurred as a result of not having the correct, or incomplete insurance information, will be your responsibility. For your convenience, we accept **Visa, MasterCard, American Express, Discover, Cash, Checks, Care Credit, Lending Club,** and **iCare.**

Consultation Fee: $95.00

Panoramic Film Fee: $133.00

X-ray Fees: $29.00 to $156.00

3D Scan First Area: $195.00, 2 Areas: $295.00

I understand the fees in this letter and agree to pay them as stated

_____ _____

Patient/Guardian Signature Date

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# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgment**

I_____, have received a copy of this office's Notice of Privacy Practices.

_____
(Signature)

_____
(Date)

**For Office Use Only**

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

__Individual refused to sign
__Communication barriers prohibited obtaining the acknowledgment
__An emergency situation prevented us from obtaining acknowledgment

__Other (Please Specify)
_____
_____
_____

Updated 10/5/17

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# Appointment Cancellation and Confirmation Policy Agreement:

Dental Specialists of North Florida is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, or "no shows" for their scheduled time, they prevent another patient from being seen. We spend considerable time and effort to confirm all appointments with you prior to your visit.

For this reason, we do require you to **verbally confirm** your scheduled appointment no later than **24 hours prior**. If we do not receive a response from you, we may schedule another confirmed appointment in your place.

**Please call us at (904)794-1000 or (386)986-1000 by 2:00 p.m. on the day prior to your scheduled appointment** to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*.** If prior notification is not given, you may be charged **$95.00** for the missed appointment.

_____

Patient Signature (Patient Parent/Guardian if under 18)

_____

Date