SALT RUN
FAMILY DENTISTRY

PATIENT INFORMATION

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

NAME _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

_____ (Date of Birth) _____ (Social Security #)

ADDRESS _____ (Street)

_____ (City) _____ (State) _____ (Zip)

_____ (Email) Consent to contact via text Yes ❑ No ❑

PHONE NUMBERS _____ (Home) _____ (Work) _____ (Cell)

EMERGENCY CONTACT _____ (Name) _____ (Phone Number)

Who may we thank for referring you today? _____ (Name)

Prefered contact method: ❑ Cell Phone ❑ Home Phone ❑ Work Phone ❑ Email

DENTAL INSURANCE

PRIMARY INSURANCE

_____ Company Name

_____ SSN of Insured

_____ Name of Insurance Carrier

_____ Policy / Group Number

_____ Insurance Address

_____ Subscriber's DOB

_____ Subscriber's Employer

SECONDARY INSURANCE

_____ Company Name

_____ SSN of Insured

_____ Name of Insurance Carrier

_____ Policy / Group Number

_____ Insurance Address

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MEDICAL HISTORY

NERVOUS SYSTEM
Y / N Frequent headaches
Y / N Numbness or tingling
Y / N Fainting or dizziness
Y / N Epilepsy/Seizures
Y / N Alzheimers
Y / N Parkinsons
Y / N Stroke
Y / N Other

BONES/JOINTS
Y / N Painful joints (including jaw)
Y / N Arthritis
Y / N Osteoporosis
Y / N Prosthetic joints (Hip, Knee, etc…)

ENDOCRINE SYSTEM
Y / N Diabetes Type I Type II
Y / N Thyroid disease

RESPIRATORY SYSTEM
Y / N Hayfever
Y / N Persistent cough
Y / N Difficulty breathing
Y / N Asthma
Y / N Tuberculosis
Y / N Emphysema
Y / N COPD

CARDIOVASCULAR SYSTEM
Y / N Congenital heart disease
Y / N Mitral valve prolapse
Y / N High blood pressure
Y / N Congestive heart failure
Y / N Angina (chest pain)
Y / N MI (heart attack)
Y / N Heart surgery (By-pass, etc…)
Y / N Prosthetic heart valves
Y / N Pacemaker
Y / N Defibrillator
Y / N Sickle cell disease
Y / N Bruise or bleed easily
Y / N Hemophilia
Y / N Anemia
Y / N Blood transfusions
Y / N HIV +/ AIDS

GI SYSTEM
Y / N Ulcers (stomach)
Y / N Hepatitis A | B | C | other
Y / N Cirrhosis
Y / N Kidney problems/ stones
Y / N Sexually transmitted disease

Are you currently required to take antibiotics prior to treatment? Y / N

OTHER
Y / N Tumors / Growths
Y / N Cancer Type _____
Y / N Chemotherapy
Y / N Radiation therapy
Y / N Steroid therapy
Y / N Recreational drug use
Y / N Psychiatric treatment
Y / N Drug addiction
Y / N Autoimmune / Immune disorders

Do you use tobacco? Y / N How much? _____

Do you drink alcohol? Y / N How much? _____

Are you on birth control medications? Y / N

Are you, or might you be pregnant? Y / N

Do you have any disease, condition, or problem not listed? Y / N

If yes, please explain: _____

_____

DRUG ALLERGIES Y / N

❑ Antibiotics _____

❑ Anesthetic _____

❑ Codeine ❑ Latex ❑ Aspirin

❑ Other _____

LIST OF CURRENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient Signature: _____

Date: _____

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FINANCIAL POLICY

PAYMENT IS DUE AT TIME OF SERVICE

Please indicate your method of payment: ❒ Cash ❒ Check ❒ Mastercard ❒ Discover ❒ Visa ❒ Care Credit

- We file your insurance for dental services; however the patient is legally and financially responsible for all cost of dental services regardless of dental insurance coverage.

- It is the patient's responsibility to notify us immediately regarding any changes to benefit coverage.

- If the insurance company denies a claim, the patient is legally and financially responsible for any service rendered.

- REMEMBER we will give only an ESTIMATE of the patient's copayment. This is an estimate based on what the insurance company provided our office. If the insurance company does not pay the estimated amount, the patient is fully responsible for the balance.

- The patient understands that insurance benefits are not a substitute for payment by the patient.

Signature _____ Date _____

If under 18 Parent or Legal Guardian _____ Date _____

Relationship to the Patient _____

Consent for Use and Disclosure of Health Information and Release Form

HIPAA
Health Insurance Portability & Accountability Act

PATIENT INFORMATION

Patient's Name _____ DOB ____/____/____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email _____

Our practice has always safeguarded and protected our valued patient's personal and health information. These safeguards meet or exceed the 2003 HIPPA (Health Insurance Portability and Accountability Act), under the Department of Health and Human Services requirements to include the September 2013 "Omnibus" updated privacy regulations.

Our practice privacy policies, in accordance, allows us to use your personal information for "normal and customary" services when required communication within the healthcare profession, both clinical and administrative, to include but not limited to: consultations with another healthcare professional such as your medical doctor or another dental specialist about your treatment and progress, assisting with patient insurance, appointment reminders, account financial information and laboratory cases.

I, _____ , have read, reviewed and considered the contents of this consent form and was given a copy of the practice's "Notice of Privacy Practices".

I understand, that by signing this Consent form, I am giving my legal consent for your disclosure and use of mine and/or my dependant's (minor child or other person(s) whom I am the legal guardian of) protected private personal and health information in any form deemed needed in the practice's professional judgement and in accordance with your normal and customary privacy and security practices.

I have the legal right to amend or revoke this Consent given at any time by providing your practice with a written and signed notice.

Our practice retains the right to decline treatment should you choose not to sign this Consent, should you choose to revoke it, or should you have what we would consider unreasonable exemptions.

_____ _____
Signature Date

_____ _____
Signature of personal representative Date

_____
Please print name of representative

☐ Request for Exemption: mark this box if you wish for any of your information not to be used for normal and customary practices within the healthcare profession. Specifically write / mark your request for exemption(s) or limitation(s) below. Specify the person(s) you do not want your information released to.

See back of this page

RECORDS RELEASE AUTHORIZATION

DATE_____

TO:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE:_____FAX:_____

EMAIL:_____

I AUTHORIZE THE RELEASE OF DENTAL RECORDS RELEVANT TO DENTAL TREATMENT, OR COPIES OF SUCH, AND REQUEST THEY BE TRANSFERRED TO:

SALT RUN FAMILY DENTISTRY
MICKEY LETH, DMD
BERT TAVARY, DDS
SABRINA WALL, DDS
700 ANASTASIA BOULEVARD
ST AUGUSTINE, FL 32080
TELEPHONE: 904-824-3540
FAX: 904-824-3541
EMAIL: office@saltrundental.com

_____ _____

PATIENT DATE OF BIRTH

_____

SIGNATURE (PATIENT, PARENT, GUARDIAN)