New Patient Registration

Patients Name: _____

DOB: _____ **Patients SS#:** _____

Single_____ Married: _____ Widowed: _____ Divorced: _____ Separated: _____

Address: _____

Street Address Apt #

_____

City State Zip Code

Home Phone: _____ **Work:** _____ **Cell:**_____

Email address:_____

Do you have any family members that come to our office? _____

In case of Emergency Contact: _____**Phone:**_____

Patient Employer: _____ **Present Position:**_____

Patient Ins: _____ **Ins Phone:** _____

Who will pay for this account:_____

Spouse/Guardian: _____ **DOB:** _____

SS#:_____ **Employer:**_____ **Ins:** _____

Who referred you to our Office? _____

Signature or Patient:_____ **Date:**_____

(Responsible party if minor)

Medical History

Patient Name: _____ DOB: _____ Age: _____

Name of Physician: _____ Phone: _____

Date of Last Medical Examination: _____ Blood Pressure: _____

Are you under the care of a physician now? _____

Are you currently taking any medications?
Please List: _____

_____

_____

***DO YOU CURRENTLY NEED TO PRE-MEDICATE PRIOR TO ANY DENTAL OR SURGICAL TREATMENT? ……. …… YES NO**

***ARE YOU CURRENTLY ON ANY BLOOD THINNERS?..... YES NO**

Do you have now or have had any of the following:

Anemia or Blood Problems	**YES**	**NO**		Neurological Problems	**YES**	**NO**
Sickle Cell Anemia	**YES**	**NO**		Kidney Problems	**YES**	**NO**
Hepatitis	**YES**	**NO**		Liver Problems or Hepatitis	**YES**	**NO**
Heart Conditions:				Epilepsy or Seizures	**YES**	**NO**
Heart Murmur	**YES**	**NO**		Cancer	**YES**	**NO**
Abnormal Heart Condition	**YES**	**NO**		Aids/Arc/HIV Positive	**YES**	**NO**
Heart Surgery	**YES**	**NO**		**Other Please List:**		
Diabetes	**YES**	**NO**		_____		
Hepatitis	**YES**	**NO**		_____		
Rheumatic Fever	**YES**	**NO**		**Allergies:**		
Joint Replacement Surgery	**YES**	**NO**		Seasonal	**YES**	**NO**
Thyroid Condition	**YES**	**NO**		Penicillin	**YES**	**NO**
Asthma	**YES**	**NO**		**Allergies To Others Medications Please List:**		
Blood Transfusion	**YES**	**NO**		_____		
Stroke	**YES**	**NO**		_____		
High Blood Pressure	**YES**	**NO**		_____		
Low Blood Pressure	**YES**	**NO**		_____		
Fainting or Dizzy Spells	**YES**	**NO**				
Excessive Bleeding	**YES**	**NO**		**Allergies To Local Anesthetics:**	**YES**	**NO**
Emotional Problems	**YES**	**NO**				

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use of disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare. I understand that diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The above organization is not required to agree to the restrictions that I may request. However, if the above organization agrees to a restriction that I request, the restriction is binding on the above organization.

I have the right to revoke this consent, in writing, at any time, except to the extent that the above organization has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care cleaning house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the above organizations Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the above organization. The Notice of Privacy Practices are also provided at the above organization and on the website if applicable. This Notice of Privacy Practices also describes my right and the above named organization's duties with respect to my protected health information.

The above named organization reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

_____ _____

Signature of Patient or Personal Representative Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

1700 N UNIVERSITY DR STE 101 | CORAL SPRINGS FL, 33071 | (954) 344-8800

Written Financial Policy

Thank you for choosing Coral Springs Dental Center. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa®, MasterCard®, American Express® or Discover Card®
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card

Please note:
J & Y Dental, d/b/a Union Dental, Union Dental Family Services and Coral Springs Dental Center requires payment at the beginning of your treatment. ALL COPAYMENTS, DEDUCTIBLES AND *PAST DUE BALANCES* ARE DUE PRIOR TO YOUR BEING SEATED.

For plans requiring more than 1 appointment, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $1,000.00 or more, a deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $25.00 is charged for patients who miss or cancel an appointment without 24 hour notice. If a deposit was placed, it will also be forfeited.

Union Dental Family Services charges $35.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.