Asbury Family Dentistry

Asbury Family Dentistry | 91 Branscomb Rd Ste 7 • Green Cove, FL 32043 (904)284-6688

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First M Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact:

_____

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Please list authorized persons with whom we may discuss your Protected Health Information in addition to custodial parents and legal guardians:

1._____Date_____

2._____Date_____

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ _____ ___ _____
Last First M Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First M

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Company Phone Number: * _____

Do you have secondary insurance? If So please provide information below:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern?

_____

_____

Date of most recent dental exam and dental x-rays: _____

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Any teeth sensitive to hot, cold, biting, sweets
- ☐ Food gets trapped between any teeth
- ☐ You have difficulty chewing
- ☐ Gums bleed when brushing or flossing
- ☐ Were told you have lost bone around teeth
- ☐ Experienced gum recession
- ☐ Had trouble getting numb
- ☐ You experience dry mouth
- ☐ Avoid brushing any part of your mouth
- ☐ Have you experienced popping and/or clicking of jaw joint
- ☐ You clench or grind your teeth
- ☐ Treated for gum disease
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, payment is due at time of services. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of sixty days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

PLEASE READ CAREFULLY AND INITIAL THE BOXES BELOW

☐ ***PAYMENT**
Full payment is due at time of service. We accept Cash, Visa, Mastercard, American Express or Discover card. WE DO NOT ACCEPT PERSONAL CHECKS.

SEE LAST PAGE FOR DEPOSIT AND NO SHOW/ CANCELLATION POLICY

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration form.**

Name of patient, parent or guardian completing this form: *

Relationship to patient: *

Signature _____ **Date** _____

Response Date: _____

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Medical History

Patient Name: _____ (Last) _____ (First) ___ (M) _____ (Preferred Name)

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Allergies
- ☐ Allergy-Adhesive
- ☐ Allergy-Keflex
- ☐ Allergy-Nickel Metal
- ☐ Allergy-Tylenol
- ☐ Artificial Heart Val
- ☐ Bleeding Abnormally
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pain Mangement
- ☐ Radiation Treatment
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Allergy - Asprin
- ☐ Allergy-Bactrim
- ☐ Allergy-Laxtex
- ☐ Allergy-Penicillin
- ☐ Alzheimers/ Dementia
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Chemotherapy
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hypoglycemia
- ☐ MS
- ☐ Parkinsons Disease
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Substance Abuse
- ☐ Ulcers
- ☐ Allergy - Codeine
- ☐ Allergy-E-Mycin
- ☐ Allergy-Levaquin
- ☐ Allergy-Shell Fish
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Circulatory Problems
- ☐ Fainting
- ☐ Heart Problems
- ☐ Immune Deficiency
- ☐ MVP
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Sjorgens
- ☐ Thyroid Problem
- ☐ Vertigo
- ☐ Allergy- Benadryl
- ☐ Allergy-Ibuprofen
- ☐ Allergy-Naproxen
- ☐ Allergy-Sulfa
- ☐ Arthritis
- ☐ Autism
- ☐ Cancer
- ☐ Cough, Persistent
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Psychiatric TX
- ☐ Shingles
- ☐ Stints
- ☐ Tramatic Brain Injur

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

_____

_____

Allergies not listed:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ○ Yes ○ No

Reason for Pre-Med and Date

_____

_____

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

○ Yes ○ No

Please list any medications you are currently taking, one medication per line:

Signature _____ **Date** _____

Response Date: _____

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Hipaa Consent Form

Mail a recall or appointment reminder to your home? ○ Yes ○ No

Leave appointment reminder on your voice mail,email, or text? ○ Yes ○ No

Leave billing or dental information via voicemail, email, or text? ○ Yes ○ No

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised copy which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions at any time by contacting: ASBURY FAMILY DENTISTRY at 904-284-6688

RIGHT TO REVOKE: You will have the right to revoke consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and health care operations.

Signature _____ **Date** _____

If this consent is signed by a personal representative (parent/guardian)on behalf of the patient, complete the following:

Personal Representative's Name_____

Relationship to Patient_____

FOR OFFICE USE ONLY

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

○ Individual refused to sign
○ Communication barriers prohibited obtaining the acknowledgement.
○ An emergency situation prevented us from obtaining acknowledgement
○ Other (please specify)_____.

Signature _____ **Date** _____

Response Date: _____

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office@asburyfamilydentistry.com

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****IMPORTANT****

We require a 24 hour confirmation for all appointments. On any appointment 90 minutes or longer we require 48 hours notice if you need to cancel or reschedule. WE REQUIRE ALL APPOINTMENTS TO BE CONFIRMED. If we do not receive a confirmation for your appointment we will consider you are not coming to your appointment and will fill that spot. We do have a answering service that is available for you to leave a message if our office is closed or we can not be reached.

To cut down on our no-show and last-minute cancelations we have implemented DEPOSITS for restorative and deep cleaning appointments. $50 per ½ hour fee is due when scheduling an appointment.

If you NO SHOW or CANCEL with less than 24-hour notice for a cleaning appointment, we will REQUIRED to pay a $25 deposit to reschedule.

We REQUIRE a 24-hour notice to cancel or reschedule to avoid losing your deposit. A new deposit will be required to reschedule an appointment.

Our NO SHOW or CANCELATION fee is $50 and must be paid to reschedule an appointment. Please CONFIRM your appointments to potentially avoid losing your reserved time.

There is a 3% surcharge for CREDIT transactions. No charge for DEBIT or CASH. WE DO NOT ACCEPT CHECKS.

After 2 missed appointments, you will be REQUIRED to pay your visit in full to reschedule.
After 3 missed appointments, you will be dismissed from the practice.

Signature (non digital form) or Name of patient,parent or guardian completing this form: *

_____

_____

Relationship to patient: *

_____

_____

Date: * _____

Response Date: _____