WinterHaven Dental.com

Patient Name (PRINT):_____ Preferred Name: _____

SSN: _____ DOB: _____ ☐ Male ☐ Female

Address: _____City: _____State:_____Zip: _____

Home #: _____ Work #:_____ Cell #: _____

Email: _____

IN EMERGENCY PLEASE CALL NAME_____ PHONE#:_____

ASSIGNMENT AND RELEASE

_____(initials) I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Russel ElHamarnah, DMD PLLC dba Winter Haven Dental all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____(initials) In addition, I understand that after 30 days my account becomes delinquent. If my account is referred for collection, I agree to be liable for payment of reasonable collection fees, including but not limited to attorney fees and court costs. I realize that I am responsible for payment of all dental services rendered to me and or my dependents , regardless of the decision regarding reimbursement made by my insurance carrier.

Responsible party (signature): _____ Date: _____

_____

Patient name (parent if minor) (Print)

Consent: I consent to the diagnostic procedures and treatment the dentist necessary for proper dental care.

Patient (signature): _____ Date: _____

_____

Patient name (parent if minor) (Print)

PRIVACY PRACTICES, BILL OF RIGHTS, ADVANCE DIRECTIVES

_____(initials) I have been provided a copy of the privacy practices (HIPPA)

_____(initials)I have been provided a copy of my rights and responsibilities

_____(initials)I have been provided a copy of my rights regarding advance directives

*****NOTE: PLEASE BE ADVISED OF OUR 24 HOUR POLICY TO CANCEL OR RESCHEDULE APPOINTMENTS****

IF YOU CANCEL OR RESCHEDULE WITHOUT A 24 HOUR NOTICE YOU WILL BE CHARGED $25.00 PER PERSON (NOT COVERED BY YOUR INSURANCE).

Patients Name:

WinterHaven Dental.com

Do you have a personal physician? ☐ Yes ☐ No

Physicians Name:_____

Physicians Phone:_____

What is the primary language in the home?_____

Do you require communication assistance (Braille, TTY, Sign Language or Interpreter)? ☐ Yes ☐ No

If 18 years or older, do you have an Advance Directive (Living Will)? ☐ Yes ☐ No

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

Have you had any surgeries in the last 5 years? ☐ Yes ☐ No

Please list all medications & surgeries on the below:

_____

_____

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Sickle Cell Disease
☐	☐	Alcohol Abuse	☐	☐	HIV + AIDS	☐	☐	Sinus Problems
☐	☐	Allergies	☐	☐	Heart Attack	☐	☐	Stroke
☐	☐	Anemia	☐	☐	Heart Murmur	☐	☐	Thyroid Problems
☐	☐	Angina Pectoris	☐	☐	Heart Surgery	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Hemophilia	☐	☐	Ulcers
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis A			
☐	☐	Asthma	☐	☐	Hepatitis B			
☐	☐	Blood Transfusion	☐	☐	Hepatitis C			
☐	☐	Cancer	☐	☐	High Blood Pressure			
☐	☐	Chemotherapy	☐	☐	High Cholesterol			
☐	☐	Colitis	☐	☐	Joint Replacement			
☐	☐	Congenital Heart Defect	☐	☐	Kidney Problems			
☐	☐	Diabetes	☐	☐	Liver Disease			
☐	☐	Difficulty Breathing	☐	☐	Low Blood Pressure			
☐	☐	Drug Abuse	☐	☐	Mitral Valve Prolapse			
☐	☐	Emphysema	☐	☐	Pace Maker			
☐	☐	Epilepsy	☐	☐	Psychiatric Problems			
☐	☐	Facial Surgery	☐	☐	Radiation Therapy			
☐	☐	Fainting Spells	☐	☐	Rheumatic Fever			
☐	☐	Fever Blisters	☐	☐	Seizures			
☐	☐	Frequent Headaches	☐	☐	STD			
			☐	☐	Shingles			

Yes	No	**Allergies**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Yes	No	If Female Please Answer
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregrant? If so, # of Weeks?_____
☐	☐	Are you nursing?

How did you hear about us?_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date:_____

Medical history reviewed by:

Signature:_____Date:_____

Broken Appointment Policy

We have more patients who need dental care than we have room in our daily schedule to provide. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who desperately needs dental care. This policy is our attempt to ensure that both you and our other patients receive the dental care that you need.

WE REQUIRE A 48 NOTICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. THE FOLLOWING WILL APPLY:

$25 BROKEN APPOINTMENT FEE FOR NEW AND RESTORATIVE PATIENT(S)

$25 BROKEN APPROINTMENT FEE FOR HYGEINE

NO CANCELLATION OR RESCHEDULING FOR PRODUCTION. BROKEN FEES ARE AS FOLLOWED:

$50 BROKEN APPOINTMENT FEE FOR ALL PRODUCTION

Late arrivals are also considered broken appointments. If you arrive after 15 minutes past the start time of your appointment, it will be given to an emergency patient.

PATIENT SIGNATURE_____ DATE_____