

Appearance Implant And Family Dentistry

6390 W Indiantown Rd #32

Jupiter, FL 33458

Ph # : 561-250-6307

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**Patient Personal Information**

Title _____	Nickname _____	Birth Date _____	Age _____
Last, First _____	Marital Status _____	Sex _____	
Address _____	Home # _____	Work # _____	
	Cell # _____	Drive Lic _____	
City, State, Zip _____	Emergency Contact _____	Emergency Phone # _____	
Email _____	Student _____	SSN _____	
Health Care Guardian Name _____	School Name _____		
Health Care Guardian Phone # _____	Referral Type _____		

Person responsible/guarantor for paying bills

Title _____	Nickname _____	Birth Date _____	Age _____
Last, First _____	Marital Status _____	Sex _____	
Address _____	Home # _____	Work # _____	
	Cell # _____	Drive Lic _____	
City, State, Zip _____	SSN _____		
Email _____			

Do you have Primary Dental Insurance?

__ Yes __ No

Do you have Secondary Dental Insurance?

__ Yes __ No

Group No/Name _____	Group No/Name _____
Insurance Name _____	Insurance Name _____
Phone # _____	Phone # _____
Employer Name _____	Employer Name _____
Subscriber Last, First _____	Subscriber Last, First _____
Subscriber Address _____	Subscriber Address _____
City, State, Zip _____	City, State, Zip _____
Relationship to Patient _____ Birth Date _____	Relationship to Patient _____ Birth Date _____
Subscriber ID _____	Subscriber ID _____

Patient Medical Information

Allergic To	<input type="checkbox"/> Y <input type="checkbox"/> N Anorexia	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Persistent Diarrhea
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters	<input type="checkbox"/> Y <input type="checkbox"/> N Premedicate
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates / Sleeping Pills	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Frequently Dry Mouth / Sjogren	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Gag Reflex	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Heart Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Gall Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid Arthritis
<input type="checkbox"/> Y <input type="checkbox"/> N Iodine	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Sexually Transmitted Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N No Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Tumor or Growth	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Prior Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Other Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain Upon Exertion	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
Check, if applicable	<input type="checkbox"/> Y <input type="checkbox"/> N Color Blindness	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Unusual Weight Loss
		<input type="checkbox"/> Y <input type="checkbox"/> N Kidney	

<input type="checkbox"/> Y <input type="checkbox"/> N No Change Since Last Recorded	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N Urinate Frequently
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Concerns or Issues	<input type="checkbox"/> Y <input type="checkbox"/> N Contact Lenses	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	Other
<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Congestive Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N See Scanned Documents: Pt Note
<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Infection	<input type="checkbox"/> Y <input type="checkbox"/> N Damaged Heart Valve	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus	
<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Problems	
<input type="checkbox"/> Y <input type="checkbox"/> N Angina	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Environmental Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker	
<input type="checkbox"/> Y <input type="checkbox"/> N Ankles Swell	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy		

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist

Phone

Date of your last cleaning

Last exam date

Date of your last full series x-rays

Date of last cavity detection (bitewing) x-rays

Do your gums bleed while brushing or flossing ?

Are your teeth sensitive to hot, cold or sweets ?

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ?

Have you ever had burning of the tongue or cracking of the corners of your mouth ?

Do you chew/smoke tobacco in any form ?

Have you had any head, neck or jaw injuries ?

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ?

Do you clench or grind your teeth ?

Have you ever had orthodontic treatment ?

If Yes, date of placement

Do you wear dentures or partials ?

If Yes, date of placement of dentures ?

Are you happy with your dentures ?

Are you having any specific problems with your teeth, gums, or mouth at this time ?

Are you happy with your smile ?

Do you have problems with teeth/fillings breaking ?

Do you regularly use dental floss ?

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ?

Do you have difficulty in opening your mouth widely ?

Do you have an unpleasant taste or odor in your teeth/mouth ?

TERMS AND CONDITIONS OF SERVICE

In consideration of all services provided by Appearance Implant & Family Dentistry of Jupiter P.A., and their employees and contractors (individually and collectively the "Dental Group"), the undersigned hereby acknowledges and agrees on behalf of himself or herself, and on behalf of his or her children, dependents, and other persons for whom he or she serves as guarantor (collectively, "Dependents"), with the following terms and conditions of service:

Medical Information. The undersigned hereby certifies that all information provided to the Dental Group is true, correct and complete and agrees to promptly inform the Dental Group of any changes in any information (including regarding any Dependent). The Dental Group is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information and medical records relating to the undersigned or any Dependent to obtain payment for services, determine insurance benefits, or otherwise as required by law. The Dental Group is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any Dependent).

Treatment; Informed Consent. The undersigned authorizes the Dental Group and any treating dentist, hygienist, and staff member to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself or herself or any Dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by the Dental Group or any dentist or any other person employed or contracted by the Dental Group regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures, and continuing care, and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show within 15 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a broken appointment fee. The Dental Group does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist's supervision) and agrees to hold harmless the Dental Group and its interest holders, members, managers, officers, directors, owners, affiliates, employees, agents, contractors, and all other persons and entities under common control or ownership with the Dental Group. **Fees in treatment plans for non-insurance/discount plan patients are only valid for 30 days; all insurance/discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.**

Financial Responsibility; Insurance. THE UNDERSIGNED PATIENT AND GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF THE DENTAL GROUP, WHETHER OR NOT COVERED BY INSURANCE. THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED. For treatment involving multiple appointments, such as a crown, root canal, denture, or implant, the entire patient portion is normally due when treatment is started. Any special financial arrangements must be made before treatment is started. All insurance, discount plans and discount coupons must be presented before treatment is started. The Dental Group submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed. The undersigned agrees to pay promptly on demand any balance not paid by insurance within 60 days after the date of service.

Insurance balances are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by the Dental Group relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. The Dental Group reserves the right to terminate or deny any treatment if the patient's account is delinquent.

Assignment of Benefits; Authorization and Release. The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to the Dental Group all insurance benefits covering the undersigned or any Dependent for all services rendered. The undersigned hereby agrees that his or her signature below will be maintained "on file"; the Dental Group is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he or she shall immediately remit such payment to the Dental Group.

Notice of Privacy Practices. The undersigned has reviewed a copy of the Dental Group's Notice of Privacy Practices effective January 1, 2022 as amended.

I have read the above terms and conditions of service by the Dental Group and understand and accept such terms:

Signature of Patient, Parent, Legal Guardian,
Health Care Proxy or Surrogate, or Power of Attorney

Date signed: _____

Printed name of Patient, Parent, Legal Guardian,
Health Care Proxy or Surrogate, or Power of Attorney

Relationship to Patient: _____ Date signed: _____

Signature of Witness

Date signed: _____

Printed name of Witness

HIPAA COMPLIANCE

Patient Consent to Receive Mail and/or Telephone Messages

Patient's Name: *(Please print)*

LAST NAME FIRST NAME MIDDLE

1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes _____ No _____

2. Do we have your permission to leave the following information on your home answering machine or voice mail?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

3. Do we have your permission to leave the following information on your work answering machine or voice mail?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Information	Yes _____	No _____
Billing Information	Yes _____	No _____
Dental/Medical Information	Yes _____	No _____

7. I hereby give permission to share any information concerning me with the person(s) named below:

Name: _____ Name: _____

DATE: _____

SIGNED: _____

WITNESS: _____

Print Name: _____

Print Name: _____

Relationship to Patient: Self _____ Spouse _____ Parent _____ Child _____ Legal Guardian _____ Other: _____