Appearance Implant And Family Dentistry
6390 W Indiantown Rd #32
Jupiter, FL 33458
Ph # : 561-250-6307
Fax #: 561-284-8189

APPEARANCE IMPLANT DENTAL OF JUPITER

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

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

Do you have Secondary Dental Insurance? __ Yes __ No

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

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Narcotics

Check, if applicable

- ☐ Y ☐ N Anorexia
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ■ N Skin Rash
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss

☐ Y ☐ N No Change Since Last Recorded
☐ Y ☐ N No Known Concerns or Issues
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Angina
☐ Y ☐ N Anemia
☐ Y ☐ N Ankles Swell
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Contact Lenses
☐ Y ☐ N Congestive Heart Failure
☐ Y ☐ N Damaged Heart Valve
☐ Y ☐ N Diabetes
☐ Y ☐ N Emphysema
☐ Y ☐ N Environmental Allergies
☐ Y ☐ N Epilepsy
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Pacemaker
☐ Y ☐ N Urinate Frequently

Other

☐ Y ☐ N See Scanned Documents: Pt Note

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 of 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.

Missed or same day cancelled appointment charge is $50.

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.

January 1, 2022 as amended.

Notice of Privacy Practices. The undersigned has reviewed a copy of the Dental Group's Notice of Privacy Practices effective

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

_____ Date signed: _____

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

_____ Relationship to Patient: _____ Date signed: _____

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

_____ Date signed: _____

Signature of Witness

_____

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: _____