

**CAMERON DENTAL STUDIO  
PATIENT MEDICAL HISTORY**

<b>Patient's Name:</b>		<b>Today's Date:</b>		<b>For Office Use Only</b>	
				ID: <input style="width: 50px;" type="text"/>	
<b>Address:</b>					
<b>City State Zip:</b>			<b>Out of State Address and Phone:</b>		
<b>Home Phone:</b>		<b>Work Phone:</b>		<b>Birth Date:</b>	<b>Social Security No.:</b>
<b>Primary Dental Insurance:</b>			<b>Occupation/Employer :</b>		
<b>Secondary Dental Insurance:</b>		<b>Cell Phone:</b>		<b>Email:</b>	
		(    )			
<b>APPOINTMENT REMINDER BY TEXT MESSAGE/EMAIL</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>					
<b>Physician Name:</b>			<b>Physician Phone:</b>		
<b>Pharmacy:</b>			<b>Pharmacy Phone:</b>		
<b>For Office Use Only</b>					
<b>Medical Alerts:</b>					

<b>Sex:</b>	<b>If female please answer the following:</b>		<b>Please answer the following:</b>	
	Y	N	Y	N
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Are you taking Birth Control Pills?		Do you smoke or use tobacco?	
	<input type="checkbox"/>	<input type="checkbox"/>	Height: <input style="width: 50px;" type="text"/>	
	Are you pregnant?      If Yes, # of weeks <input style="width: 30px;" type="text"/>		<b>For Office Use Only</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	BP: <input style="width: 40px;" type="text"/>	Heart Rate: <input style="width: 40px;" type="text"/>
	Are you nursing?		Weight: <input style="width: 40px;" type="text"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		

<table border="0"> <tr><th>Y</th><th>N</th><th><b>Conditions</b></th></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Angina Pectoris</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Bones</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input 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# PATIENT DENTAL HISTORY

When was your last dental visit? \_\_\_\_\_

Did you have x-rays taken at that time? YES  NO

How often do you brush your teeth? \_\_\_\_\_ How often do you floss your teeth? \_\_\_\_\_

Have you ever been in an accident where you experienced any type of trauma to your jaw? YES  NO

Do you see a dental specialist on a regular basis?..... YES  NO  Specialty: \_\_\_\_\_

Do any of your teeth ache?..... YES  NO

Do you have sensitivity to hot, cold or sweets?..... YES  NO

Do your gums bleed easily when you brush?..... YES  NO

Do you wish your teeth were whiter?..... YES  NO

Do you wish your teeth were a different shape?..... YES  NO

Is there anything that interests you about improving your smile or function of your teeth? YES  NO

If so, what interests you? \_\_\_\_\_

Is there anything that you think the dentist should know about your dental history that is not mentioned above? YES  NO

If so, what ? \_\_\_\_\_

What did you like about your previous dentist? \_\_\_\_\_

What did you dislike about your previous dentist? \_\_\_\_\_

How did you find out about our office?

Online  Naples Daily News  Brochure  Other   
Friend/Relative  If so, whom may we thank for referring you? \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_

Method of Payment:

Visa # \_\_\_\_\_ Exp. \_\_\_/\_\_\_ Billing Address \_\_\_\_\_

MC # \_\_\_\_\_ Exp. \_\_\_/\_\_\_ Billing Address \_\_\_\_\_

Amex # \_\_\_\_\_ Exp. \_\_\_/\_\_\_ Billing Address \_\_\_\_\_

Other \_\_\_\_\_ Exp. \_\_\_/\_\_\_ Billing Address \_\_\_\_\_

I, the undersigned, certify that the information that I have provided in this Patient Information Questionnaire is true and accurate to the best of my knowledge. I have not knowingly omitted any information that may be important to the dentist and his/her staff. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I consent to my physician, other dentists or dental specialists being contacted for consultation if needed. I authorize release of my treatment to my insurance company. I understand that it is my responsibility to inform the dentist of any changes in my personal information and medical condition as it relates to this questionnaire.

I accept full responsibility for payment of all fees for my dental treatment. I authorize for my credit card listed above to be charged for any of my outstanding balances, including, but not limited to, any balances not paid by my insurance company within 40 days from the date of the claim submission.

Signature (Patient / Guardian) \_\_\_\_\_ Date: \_\_\_\_\_

# Financial Policy

Thank you for choosing **CAMERON DENTAL STUDIO** for all your dental needs. We are committed to providing you with excellent dental care. The following is statement of our **Financial Policy**, which we require you read, agree to, and sign prior to any treatment. Please understand that this financial policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases.

**Full payment is due at the time of service.**

**We accept as payment:**

- **Visa**
- **MasterCard**
- **American Express**
- **Discover Card**
- **Debit (Check) Cards**
- **Cash**
- **Checks**

**Insurance:** We may accept assignment of primary insurance benefits; however, we do require deductibles and co-payments to be paid at the time of service:

1. At each visit, we will ESTIMATE your co-payment to the best of our ability, given all the information we have about your benefits. Any information that we receive from your insurance company about your benefits over telephone is NOT a guarantee of payment by the insurance. Therefore please note that your account with us is not settled or adjusted until your insurance company processed the claim, and you have paid all outstanding balances.
2. There may be an ADDITIONAL balance that is your responsibility to pay if the insurance company has reduced payment, denied payment, downgraded procedure(s) to the cost of least expensive treatment, you have exceeded your annual maximum or any of the procedures performed are not a benefit under your insurance plan. In case where there is a balance, you will receive a billing statement that you agree to pay.

Your insurance policy is a contract between you, your employer and your insurance company; we are not a party to that contract nor are we responsible for procedures that are not covered for any reason. Any treatment that is recommended to you is based on your needs, and not on whether or not it is a covered benefit under your insurance. We must have complete and up to date insurance information in order to bill your insurance company on your behalf. In the event that your insurance company has not paid their portion within 40 days, **\*\*\*\*\*any outstanding balance will become your responsibility\*\*\*\*\***

**Finance Charges:** A finance charge will be billed to any account in which the balance remains unpaid for 60 days without payment arrangements. This monthly fee will equal 18% APR.

**Collection Fees:** When an account becomes 90 days past due, your account may be assigned to a collection agency. In this event, you will be responsible for all collection and legal fees, which may exceed the outstanding balance by up to 50% plus legal fees.

**Missed Appointments:** Unless cancelled at least **24 hours** in advance, our policy is to charge **\$50.00** for missed, broken or short-cancelled appointments. In order to be fair to all our patients and our office this policy is strictly enforced, and after three (3) missed, broken or short-cancelled appointments you will be dismissed from our practice. Please help us to serve you more efficiently by keeping scheduled appointments.

**Returned Checks:** If a check is returned NSF, there will be a **\$25.00** NSF charge and, from that point on, checks will not be accepted. Outstanding amount (including NSF charge) must be paid immediately, failing which the account is handed over to Collections.

I, the undersigned, assume financial responsibility as stated above and responsibility for all collection and legal fees if my account becomes past due. I have read, understand, and agree to this **Financial Policy**.

X \_\_\_\_\_  
**Signature of Responsible Party**

\_\_\_\_\_ **Print name**

\_\_\_\_\_ **Date:**

**CAMERON DENTAL STUDIO**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION UNDER HIPPA**

**SECTION A:**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**SECTION B: TO THE PATIENT/PARENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**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.

**Notice of Privacy Practices:** 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 as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, 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 of our Notice, at any time by contacting:

**Contact Person:** Dr. Andrea Cameron, Telephone: (239) 307-5445 Fax: (239) 307-5445. Address: 9400 Fountain Medical Court, Suite 101 B, Bonita Springs FL 34135 E-mail: [info@camerondentalstudio.com](mailto:info@camerondentalstudio.com)

**Right to Revoke:** You will have the right to revoke this 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 activities and health care operations. I am entitled to a copy of this consent after I sign it and will request it if desired.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_