CAMERON DENTAL STUDIO

PATIENT MEDICAL HISTORY

Patient's Name: | **Today's Date:** | **For Office Use Only ID:**

Address:

City State Zip: | **Out of State Address and Phone:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Insurance: | **Occupation/Employer :**

Secondary Dental Insurance: | **Cell Phone:** ( ) | **Email:**

APPOINTMENT REMINDER BY TEXT MESSAGE/EMAIL ☐ YES ☐ NO

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

ARE YOU CURRENTLY TAKING BLOOD THINNERS? _____YES _____NO

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height:
For Office Use Only			
BP:		Heart Rate:	Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Heart Murmur
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sinus Problems
☐	☐	Stroke

Y	N	Conditions
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice
☐	☐	Heart Murmur

Do you need ANTIBIOTICS before any dental treatment? Y ☐ N ☐

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

List ALL medications you are on:

_____

_____

_____

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 □ Insurance □ Print Media □ 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 weather 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) 422-7775. Address: 1008 Goodlette-Frank Road North, Suite 100, Naples FL 34102, E-mail: 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 heath 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: _____