ST. AUGUSTINE DENTAL WELLNESS CONFIDENTIAL

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out the following forms completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help!

Patient Registration Information

Patient Information:

Name: _____ Preferred Name: _____
Last First Initial

Gender: ☐ Male ☐ Female

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Driver's License Number: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred Contact Method: Phone - ☐Home ☐Cell ☐Work ☐Email ☐Text Message

Who is responsible for this account? _____ Relationship: _____

Home Address:

_____

_____

Billing Address: ☐ Same as Home

_____

_____

Work Information:

Employer: _____

Occupation: _____

Work Phone: _____

Other family members in our practice?

_____

_____

Spouse/Parent Information:

Name: _____

Gender: ☐ Male ☐ Female

Date of Birth: _____

Social Security Number: _____-_____-_____

Employer: _____

Occupation: _____

Insurance Information:

Do you have dental insurance? ☐ Yes ☐ No

Dental Insurance Company: _____ Ins. Phone #: (_____) _____

Name of Insured: _____ Subscriber ID: _____

Subscriber DOB: _____/_____/_____ Employer: _____

Emergency Contact:

Full Name: _____ Relation: _____

Please Continue ➲

Contact Phone Number: (_____) _____

Additional Insurance:

Do you have any additional dental insurance? ☐ Yes ☐ No

If yes, please complete the following:

Name of Insured: _____ Relationship: _____

Dental Insurance Company: _____ Ins. Phone #: (_____) _____

Subscriber ID: _____ Group Number: _____

Subscriber DOB: _____/_____/_____ Employer: _____

Authorization, Release, and Agreement to Pay for Services Rendered:

I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent(s).

X_____ _____

Signature of Patient or Parent/Guardian if Minor Date

Financial Arrangements:

For your convenience, we offer the following methods of payment:

Please check the option with which you prefer to pay your deductible, co-payment, and/or non-covered benefits today.

☐ Cash ☐ Personal Check ☐ Credit Card (Visa/MC/AMEX/Discover) ☐ Care Credit ☐ Chase Health Advance

Ask us about our financing options available to you!

How did you hear about our office? ☐ PPO Insurance Provider List ☐ Yellow Pages – AT&T Book

☐ YP.com ☐ Google ☐ Bing ☐ Yahoo ☐ MINT Magazine ☐ Money Pages

☐ YellowBook Phone Book ☐ LocalEdge ☐ Direct Mail ☐ Street Signs ☐ PennySaver ☐ Billboard

☐ Hospital/Doctor's Office: _____ ☐ Referring Patient: _____

☐ Referring Dentist: _____ ☐ Other: _____

*****Referral Program: If you are a patient in our office & refer 3 other new patients who participate in our dental services, you will receive a special "Thank You" bonus.*****

Prescription Drug Policy:

Due to the nature of our practice, please be advised that ST. AUGUSTINE Dental Wellness 1) Does not provide narcotics for chronic pain management. 2) Does not dispense OXYCODONE or any other Class 2 drug. 3) Does not authorize refills for antibiotics without a follow-up visit for reevaluation of your dental condition. 5) Is not responsible for lost or stolen prescriptions.

Guarantor/Patient Agreement:

I hereby agree to the following: (i) I am responsible for the charges of all services the "Patient" receives for, or related to, or connected with this visit(s), and same are due and payable at the time of discharge or discontinuation of treatment. The charges I agree to pay are readily available from any ST. AUGUSTINE Dental Wellness staff member and I am fully aware payment is due at the time dental services are provided. (ii) If ST. AUGUSTINE Dental Wellness bills third party payers*, they do so as a courtesy, and St. Augustine Dental Wellness may demand payment in full of any balance due, at any time. (iii) I understand that ST. AUGUSTINE Dental Wellness may bill me separately. (iv) If I am more than thirty **(30) days** overdue in the payment of any bill, **a finance charge** will accrue on the unpaid balance every month until paid in full.** (v) If I am more than ninety (90) days overdue on the payment of the final bill, I may be declared in default, and the overdue account may be referred to a collection agency, in which case I agree to pay attorney's fee, court costs, and/or collection agency fees associated with the collection process.

Please Continue ➲

Insurance Verification Policy:

Our staff will do everything possible to verify your insurance benefits and eligibility. If treatment is provided AFTER HOURS or on WEEKENDSAND WE ARE UNABLE TO VERIFY YOUR DENTAL INSURACE COVERAGE please be advised that due to the nature of our practice, payment for services is expected at the time of service. We accept Cash, Checks (must be imprinted with name and address, and will be electronically scanned), Debit Cards, MasterCard, Visa, and Discover. ST. AUGUSTINE Dental Wellness accepts most insurance plans and will be happy to file your insurance provided the eligibility, deductible, and co-payment amounts can be verified prior to the rendering of services. Otherwise, PAYMENT IN FULL WILL BE EXPECTED AT THE TIME SERVICE IS RENDERED. For your convenience, ST. AUGUSTINE Dental Wellness can either submit the claim on your behalf to your insurance company or applied toward your annual deductible, whichever is applicable.

****Late Charges:**

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and additional attorney fees incurred in attempting to collect on this amount or any further outstanding account balances.

*Third party payers include, but are not limited to, coverage available from Tri-Care or governmental programs; dental, accident, automobile, or other insurance; workers compensation; PPO (commercial); self-insured employers; and any sponsors who may contribute payment for services.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions or concerns at any time, please ask us. We are always happy to assist you.

Please Continue ➲

PAYMENT POLICY FOR ALL MAJOR PROCEDURES/APPOINTMENT RESERVATIONS

To reserve an appointment for any and all major procedures, or procedures exceeding $500.00 in value, St. Augustine Dental Wellness requires a deposit of $150.00. The deposit must be made a minimum of 48 hours prior to appointment date. This amount will be applied towards total out of pocket expense for patient procedures performed on that day of service.

If you need to cancel or re-schedule the appointment, we require a 48 hour notification of the cancellation or request for re-scheduling of appointment to another day. If we are not notified 48 hours prior you will be charged a fee according to the guidelines stipulated in the new patient paperwork. If applicable this amount will be deducted from the deposit made to reserve appointment.

I have read and understand the above policy of ST. AUGUSTINE DENTAL WELLNESS, LLC

_____ ____ _____

Patient Signature Date

Please Continue ➲

Patient Dental History

Patient's Name: _____ **Date of Birth**: ____/____/_____

REASON FOR THIS VISIT: _____

DO YOU WANT US TO LIMIT YOUR TREATMENT TO THIS CHIEF COMPLAINT? ☐ YES ☐ NO

WHEN WAS YOUR LAST DENTAL VISIT? _____ WHAT WAS DONE THEN? _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN? _____

PREVIOUS DENTIST (NAME & LOCATION): _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN? ☐ YES ☐ NO ☐ NOT SURE

IF SO, WHEN/WHERE? _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ HOW OFTEN DO YOU FLOSS YOUR TEETH? _____

IS YOUR DRINKING WATER FLUORIDATED? ☐ YES ☐ NO ☐ NOT SURE

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐	DO YOU BITE YOUR LIPS OR CHEEKS OFTEN?	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	☐	☐
DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	☐	☐	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐	HAVE YOU EVER WORN A BITE PLATE OR OTHER APPLIANCE?	☐	☐
HAVE YOU HAD ANY HEAD/NECK/JAW INJURIES?	☐	☐	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW:			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
CLICKING	☐	☐	DO YOU WEAR DENTURES OR PARTIALS?	☐	☐
PAIN (JOINT/EAR/SIDE OF FACE)	☐	☐	IF YES, DATE OF PLACEMENT: _____		
DIFFICULTY IN OPENING OR CLOSING	☐	☐	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	☐	☐
DIFFICULTY IN CHEWING	☐	☐			
DO YOU HAVE FREQUENT HEADACHES?	☐	☐			
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

_____

AUTHORIZATION & RELEASE:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

DOCTOR'S COMMENTS: _____

_____

_____ **SIGNATURE:** _____ **DATE:** _____

Patient Medical History

Patient's Name: _____ **Date of Birth**: ____/____/_____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
ARE YOU IN GOOD HEALTH?	☐	☐
HAVE HERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	☐	☐
DATE OF YOUR LAST PHYSICAL EXAM: _____		
PHYSICIAN'S NAME: _____		
ADDRESS: _____		
PHONE NUMBER: _____		
ARE YOU UNDER THE CARE OF A PHYSICIAN?	☐	☐
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
PLEASE EXPLAIN: _____		
_____		
ARE YOU TAKING ANY MEDICINE(S), INCLUDING NON-PRESCRIPTION MEDICATION(S)?	☐	☐
PLEASE LIST: _____		
_____		
HAVE YOU HAD ANY ABNORMAL BLEEDING?	☐	☐
DO YOU BRUISE EASILY?	☐	☐

	YES	NO
HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	☐	☐
HAVE YOU HAD RECENT WEIGHT LOSS?	☐	☐
HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
DO YOU USE TOBACCO?	☐	☐
DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES?	☐	☐
ARE YOU WEARING CONTACT LENSES?	☐	☐
DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	☐	☐
DO YOU HAVE A DISEASE, CONDITION, OR PROBLEM NOT LISTED YOU THINK I SHOULD KNOW ABOUT?	☐	☐
WOMEN ONLY:		
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

- Continued on the next page -

Please Continue ➲

Patient Medical History - continued

	YES	NO		YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			HIVES OR SKIN RASH	☐	☐
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐	FAINTING OR DIZZY SPELLS	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	DIABETES	☐	☐
SULFA DRUGS	☐	☐	AIDS OR HIV INFECTION	☐	☐
BARBITURATES, SEDATIVES, OR SLEEPING PILLS	☐	☐	THYROID PROBLEMS	☐	☐
ASPIRIN	☐	☐	ALLERGIES	☐	☐
IODINE	☐	☐	ARTHRITIS OR RHEUMATISM	☐	☐
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐
LATEX/RUBBER	☐	☐	STOMACH ULCER	☐	☐
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE	☐	☐
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			TUBERCULOSIS	☐	☐
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐	PERSISTENT COUGH	☐	☐
SCARLET FEVER	☐	☐	COUGH THAT PRODUCES BLOOD	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐	CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
HEART TROUBLE/HEART ATTACK/ANGINA	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐
CHEST PAIN	☐	☐	EPILEPSY OR SEIZURES	☐	☐
SHORTNESS OF BREATH	☐	☐	ANEMIA	☐	☐
PACEMAKER	☐	☐	GLAUCOMA	☐	☐
HEART SURGERY	☐	☐	NERVOUSNESS	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐	TONSILLITIS	☐	☐
CONGENITAL HEART PROBLEM	☐	☐	TUMORS	☐	☐
SWELLING OF FEET, HANDS, ANKLES	☐	☐	MENTAL HEALTH CARE	☐	☐
HEPATITIS, JAUNDICE, OR LIVER DISEASE	☐	☐	BACK PROBLEMS	☐	☐
STROKE	☐	☐	CHEMICAL DEPENDENCY	☐	☐
SINUS TROUBLE	☐	☐	MITRAL VALVE PROLAPSE	☐	☐
LUNG/BREATHING PROBLEMS	☐	☐	CORTISONE TREATMENT	☐	☐
ASTHMA OR HAY FEVER	☐	☐	COLD SORES/FEVER BLISTERS	☐	☐

Do you take blood thinner yes or no Do you take Aspirin yes or no

Have you ever taken medication for **the treatment of osteoporosis**, either orally or through IV route?

Yes or No

If yes, what medication and what dosage?_____

DOCTOR'S COMMENTS: _____

_____

_____ **SIGNATURE:** _____ **DATE:** _____

Please Continue ➲

St. Augustine Dental Wellness

10 St Johns Medical Park Dr.
Suite A
St Augustine FL 32086

Phone: (904) 770-2686
www.staugustinedentalwellness.com

MISSED/CANCELED APPOINTMENT POLICY

To Our Valued Patients:

If you find you are unable to keep a scheduled appointment, we would appreciate it if you could kindly give us notice. While we understand the fact that sometimes unavoidable situations may occasionally arise, we reserve the right to assess the following missed appointment charges:

- 1 Hour Appointment: $25 (without 24 hour notice)
- 2 Hour Appointment: $50 (without 48 hour notice)
- 2 ½ Hours or More Appointment: $100 (without 72 hour notice)

Thank you for your cooperation and understanding,

St. Augustine Dental Wellness, LLC

Patient Signature Date

Parent/Guardian Signature Date

TREATMENT PLAN POLICY

Treatment plans are an estimate valid for 90 days from the date entered. If during the course of treatment it becomes imperative to alter plans, you will be informed of any necessary changes. The estimate of benefits is not a guarantee of payment by insurance. Benefits are affected by eligibility at the time of service, policy provisions and limitations, and benefits that may have been paid to another office. The estimate of benefits is based on information that your insurance carrier provided to our office. We do all we can to correctly estimate your out-of-pocket expenses, but please be aware that you as the policy holder are responsible to know the coverage provided by your policy. You are ultimately responsible for all charges.

Signature Date

Please Continue ➲

ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I have received a copy of the Joint Notice of Privacy Practices St. Augustine Dental Wellness LLC, Angella Tursunov, D.M.D. & Associates.

_____

Please Print Name

_____

Signature

_____

Date

**You may refuse to sign this acknowledgement.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Joint Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining the acknowledgement.

☐ Other (please specify): _____

_____

_____

_____

Please Continue ➲

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in form, whether electronically, on paper, or orally, be kept properly confidential. This act gives you, the patient, significant rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- **Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include referring to a specialist.

- **Payment:** obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilizing review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health Care Operations:** the business aspects of running our practice, such as conducting quality assessment and improvement activities, including functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please Continue ➲

CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless/until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking, antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure, or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations, or gums.
5. Possible deterioration of your condition, which may result in tooth loss.
6. The need for replacement of restorations, implants, or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment, or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication.
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Signature	Date	Witness Signature	Date
Print Patient Name		Parent/Legal Guardian	Date

Please Continue ➲