PATIENT REGISTRATION

First Name _____ Middle Initial _____ Last Name _____
I like to be called _____ Male _____ Female _____
Date of Birth _____/_____/_____ Age: _____ Social Security _____ - _____ - _____
Drivers License No. _____
Address _____ City _____ State _____ Zip _____
Home Phone ( )_____ Cell Phone ( )_____
Work Phone ( ) _____ Method of contact re: appt ( ) text ( ) e-mail ( ) home ( ) cell
Name of Employer _____ Occupation _____
Address _____ City _____ State _____ Zip _____
Previous Dentist Name?_____ Treatment rendered _____
Who May We Thank for Referring You to Our Office _____

Account Information

Responsible Party's Name _____
Address _____ City _____ State _____ Zip _____
Home Phone ( )_____ Work Phone ( )_____ Ext _____
Social Security No. _____ - _____ - _____ Date of Birth _____ / _____ / _____
Drivers License No. _____

Dental Insurance Information – PRIMARY

Employee's Name _____
Name of Employer _____
Employee's Social Security No. _____ - _____ - _____ Date of Birth _____ / _____ / _____
Insurance Co. Name _____
Insurance Co. Address_____ City _____ State _____ Zip _____

Dental Insurance Information – SECONDARY

Employee's Name _____
Name of Employer _____
Employee's Social Security No. _____ - _____ - _____ Date of Birth _____ / _____ / _____
Insurance Co. Name _____
Insurance Co. Address_____ City _____ State _____ Zip _____

Who should we contact in the unlikely event of an emergency:_____
Name Phone No.

INFORMED CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any medical status, contact information, marital status and insurance information. I authorize the dental staff to perform any necessary dental services, such as x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I also authorize the doctor (and his/her employees for assistance when applicable) to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan. Even though I may have dental insurance coverage, I understand payment for services rendered is my responsibility. It is my understanding that payment is due at the time of service, unless other financial arrangements have been made.

Patient Signature _____ Date _____

Financial Coordinator _____ Date _____

MEDICAL HISTORY FORM

First Name _____ Middle Initial _____ Last Name _____
Are you currently under the care of a physician? □ No □ Yes
If yes, for what reason:_____
When was your last physical exam?_____
Physicians Name_____
Address_____ Phone ( )_____ Last Seen?_____
Have you ever been hospitalized or had surgery? □ No □ Yes
If yes, please explain _____
Are you taking any prescription medication? □ No □ Yes
If yes, please explain _____
Are you taking any over the counter medication? □ No □ Yes
If yes, please explain _____
Do you take appetite suppressants? □ No □ Yes – Name of Product _____
Do you have any problems with antibiotics or anesthetics? □ No □ Yes
If yes, please explain _____

Are You Allergic to Any of the Following?

□ No □ Yes Penicillin	□ No □ Yes Codeine
□ No □ Yes Aspirin	□ No □ Yes Tetracycline
□ No □ Yes Erythromycin	□ No □ Yes Germicides/Pesticides
□ No □ Yes Latex and/or Rubber products	□ No □ Yes Other _____

Are you allergic to any other medications or substances? □ No □ Yes
If yes, please explain _____

Circle if you have ever had any of the following diseases or medical conditions:

Heart Attack/Stroke	Venereal Disease	Diabetes
Cancer/Chemotherapy	Herpes Type I	Tuberculosis
Heart Murmur	Herpes Type II	Hemophilia
Rheumatic Fever	Anemia	Blood Transfusion
HIV/AIDS	Difficulty Breathing	High Blood Pressure
Hepatitis A	Asthma	Low Blood Pressure
Hepatitis B	Sinus Problems	Radiation Treatment
Hepatitis C	Psychiatric Problem	Kidney Problems
Hepatitis D	Do You Smoke?	Artificial Valves
Artificial Bones/Joints	Epilepsy	Headaches
Mitral Valve Prolapse	Fainting	Shingles
Pace Maker	Seizures	Emphysema
Delayed Healing	Heart Surgery	Glaucoma
Stomach Problems / Ulcers	Do You Consume Alcohol?	

For Women Only: Circle if taking the following:
Birth Control Pills Pregnant/No of Months _____ Nursing Hormone Therapy

PATIENT SIGNATURE: _____ Date_____

DOCTOR SIGNATURE: _____ Date_____

† STARLING FAMILY DENTISTRY, P.A. †
† TRACIE C. STARLING, DMD †

WELCOME

Welcome to our office! We hope you find the atmosphere to be comfortable and the office staff courteous. Our ultimate goal is to provide you with high quality dental care. As an attempt to have good communication with our patients, we would like for you to be aware of some of our office policies and philosophy.

INSURANCE

As a courtesy to you, our office will file your insurance claim for you; however, it is your duty to know the limits and coverage of your particular dental insurance policy. Our office is currently contracted or **"In Network"** with the following insurance companies: **Aetna (effective 3/1/14), Assurant, Delta Dental PPO (Delta Premiere), Florida Combined Life, MetLife and United Concordia**. We are considered "Out-of-Network" on any other insurance company not listed. We will file a claim with your insurance company at the time of your visit and give you our best estimate of your portion of the claim. We cannot keep up with the specific guidelines of every patient's policy, so we will practice dentistry to the best of our ability and make recommendations that are in your best interest. We need to know when you see another dental provider to help you evaluate your dental insurance maximum for the year. We do our best to give you an estimate of your portion, but this is only an estimate, not a guarantee, for we cannot guarantee insurance coverage for any procedure. Your estimated portion is expected to be paid at the time we provide our service to you. This estimated portion will be collected before you are seated for major procedures such as crowns, root canals, bridges, partial or full dentures, whitening, and some oral surgery. If you have any questions, please ask before you are seen. If your insurance pays more than expected, you will be issued a credit or check, and if it is less than expected, an invoice will be sent to you for completion of payment. If payment is not received within sixty (60) days from your insurance company for any procedure, you will be responsible for full payment of that procedure. I understand Starling Family Dentistry can only estimate insurance benefits and will file my insurance claims as a courtesy. It is my responsibility to know my insurance yearly maximums, co-pays, and deductibles.

When seeing our hygienists, we do require necessary x-rays, doctor exams and fluoride treatments to insure your optimum dental health as well as allow Dr. Starling to make a decisive diagnosis of your dental health. Your insurance may/may not cover these procedures and we DO NOT allow insurance companies to dictate the quality of treatment we administer.

APPOINTMENTS/CANCELLATIONS

Please be aware we ask you to give us twenty-four (24) hour notice if you need to cancel or reschedule your appointment. If you are not present for your appointment, or cancel the same day, there will be a seventy-seven ($79.00) dollar charge. This policy allows us to make your appointment available for other patients waiting to be seen.

***Service Charge: A service charge of 1.5% per month (18% APR) will be charged unless prior arrangements have been made. Patient (parent, if minor) understands that if this account is placed with a collection agency, that he/she will be responsible for any collection and/or attorney's fees, plus costs.

If you have any questions, please do not hesitate to ask for assistance before the doctor evaluates you. Thank you for choosing our office team to provide your dental care needs. We want to keep you smiling!

_____

Patient Signature/Parent (if Minor) Date

Consent for Use and Disclosure of Health Information and Release Form

PATIENT INFORMATION

HIPAA Certified — Health Insurance Portability and Accountability Act

Patient's Name________________________ DOB_____/_____/________

Address ____________________________ City______________ State____ Zip____

Home Phone (______)__________________ Work Phone (______)________________

Cell Phone (______)__________________ Email ____________________________

Our Practice has always safeguarded and protected our valued patient's personal and health information. These safeguards meet or exceed the 2003 **H.I.P.A.A.** *(Health Insurance Portability and Accountability Act), under the Department of Health and Human Services* requirements to include the September 2013 "*Omnibus*" updated Privacy regulations. Our Practice Privacy policies, in accordance, allows us to use your personal information for "Normal and Customary" services when required communication within the Healthcare profession, both clinical and administrative to include but not limited to: Consultations with another Healthcare professional such as your medical doctor or another dental specialist about your treatment or progress, assisting with patient insurance, appointment reminders, account financial information and laboratory cases.

Request For Exemption(s) – Mark this box if you wish for any of your information **NOT** to be used for normal and customary practices within the Healthcare Profession. Specifically write your request for exemption*(s)* or limitation*(s)* below. *Example: No calls to work phone.*

**Practice Use Only:* *Exemption(s) Declined, Patient Informed. Signature/Date:*____________________

Who May We Release Information to: – Please specify anyone you authorize our Practice to release information and what type of information we may give out, if requested and approved, about you, your treatment, progress or account. Usually this is a spouse or significant other, Parent or Guardian, Grandparents, adult children or whomever you choose to authorize our Practice and our Healthcare Associates to release information to.

PLEASE PRINT COMPLETE NAME*(s)* AND LEGAL RELATIONSHIP TO PATIENT.

Complete Name Relationship Date	***Complete Name*** Relationship Date
Type of Information authorized to release:	***Type of Information authorized to release:***
NO RESTRICTIONS FOR THIS INDIVIDUAL	**NO RESTRICTIONS FOR THIS INDIVIDUAL**
Treatment / Condition *Financial / Administration*	*Treatment / Condition* *Financial / Administration*
Complete Name Relationship Date	***Complete Name*** Relationship Date
Type of Information authorized to release:	***Type of Information authorized to release:***
NO RESTRICTIONS FOR THIS INDIVIDUAL	**NO RESTRICTIONS FOR THIS INDIVIDUAL**
Treatment / Condition *Financial / Administration*	*Treatment / Condition* *Financial / Administration*

I have read, reviewed and considered the contents of this Consent form and was given a copy of the Practice's "Notice of Privacy Practices". I understand, that by signing this Consent form, I am giving my legal consent for your disclosure and use of mine and/or my dependants *(Minor Child or other person(s) whom I am the legal guardian of)* protected Private personal and health information in any form deemed needed in the Practice's professional judgment and in accordance with our normal and customary Privacy and Security practices. You have the legal right to amend or revoke this Consent given at any time by providing us written notice.

Signature **(Adult)** Date	***Signature*** **(Adult)** Date
Patient Parent Legal Guardian Other *(Specify)*	Patient Parent Legal Guardian Other *(Specify)*