

Perfect Smile Dental Studio

24632 State Road 54 • Lutz, FL 33559

(813)948-6335

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ Best time to call: _____
Home Mobile Work Ext

Address: _____
Address 1 Address 2

City State Zip Code

If you are the parent/guardian of the patient, please indicate your name and date of birth.

What is the best way to communicate with you?

E-mail Home phone Mobile phone Work phone Text message

Whom may we thank for referring you to our practice?

Dental Office Yellow Pages Internet Newspaper
 School Work Other (name below):

Name of person, office, or other source referring you to our practice:

Employment Information

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ Email Address: _____

Phone: _____ Best time to call: _____
Home Mobile Work Ext

Address: _____
Address 1 Address 2

City State Zip Code

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Medical History

Have you been under the care of a Physician for anything other than routine, during the past two years?

Yes No

If yes, for what? Please indicate Physicians name and contact phone number.

Are you currently taking any drugs or medications? (Included but not limited to, vitamins, supplements, pain, recreational) *

Yes No

If yes, please indicate medications and dosage, and directions of use.

Have you taken any prescription drugs for weight loss in the past 2 years? * Yes No

If yes, please indicate medication and dosage.

Do you have any allergies? (seasonal, antibiotics, latex, base metals, any other medications) Yes No

If yes, please indicate drug and reaction.

Women: Are you pregnant or think you may be pregnant? Yes No

Have you been hospitalized within the past five years? Yes No

If yes, please indicate reason and how long.

Any complications? Yes No

If yes, please indicate complication.

If you suffer from any of the following, please indicate:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> ADD/ADHD/Autism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> HPV |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> NO EPI | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Pre Med | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | | | |

Relationship to patient

- Self Parent/Guardian

By signing this form, I acknowledge that I have read this statement and agree to the content.

Signature:

Response Date:

____/____/____

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Response Date:

____/____/____

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Consent For Treatment

I hereby authorize doctor or designated staff to take x-rays, study models and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.

I give consent to the doctor or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due in advance, (pre-paid), unless other arrangements have been made.

By checking this box, I acknowledge that I have read this statement and agree to the content.

Relationship to Patient

Self Parent/Guardian

Print Patient Name

Signature:

Response Date:
____/____/____

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HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and Disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to Dr Ana Maria Bush.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Please list below name(s) of the individual(s) you authorize our office to discuss care with, (if any). Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

By checking this box, I acknowledge that I have read this statement and agree to the content.

Print Patient Name

Relationship to Patient

Self Parent/Guardian

Signature:

I authorize Perfect Smile Dental Studio to release my records or any information about my treatment to :

Response Date:

____/____/____

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Photo Authorization

I do hereby authorize Perfect Smile Dental Studio to take photographs, slides, and/or video of my face, jaw, and the hard/soft tissue of my mouth.

I understand that these photographs, slides, and /or videos will be a part of my permanent dental records.

I also understand that these photographs, slides, and /or videos, may be used for educational, and professional purposes only. (may be displayed on our office website)

Please indicate the selection that applies to you:

- I do not consent to any pictures, slides, and/or videos.
- I consent to the use of my pictures, slides, and/or videos for office use only.
- I consent to the use of my pictures, slides, and/or videos for office use only as well as to be posted on the office website as mouth shots only(will not show my face), for before and after purposes
- By checking this box, I acknowledge that I have read this statement and agree to the content.**

Relationship to patient:

- Self
- Parent/Guardian

Signature:

Response Date:

____/____/____

Perfect Smile Dental Studio
24632 State Road 54
Lutz, FL 33559
(813)948-6335 Fax: (813)948-6394
Email: anamariabushdds@verizon.net

Office Policy

Dr. Bush and her team would like to thank you for choosing Perfect Smile Dental Studio for your dental needs. We have adopted these policies to help ensure a smooth relationship.

RESCHEDULING/CHANGE IN SCHEDULE POLICY

Appointments are reserved exclusively each patient. If the patient finds that they must change their appointment, we require a minimum of 24 working hours notice so that we may make every effort to accommodate other patients. If we are not notified within this time frame, we reserve the right to charge a broken appointment fee of \$65.00 (limited exceptions will be made). In addition, multiple failed appointments will result in being placed on a "call" list and will only be called for appointments on a short notice basis. No regular appointments will be given.

APPOINTMENT CONFIRMATION

Appointments should be confirmed via e-mail, text, and/or phone call. If the appointment is not confirmed 24 hours prior to its occurrence, we reserve the right to utilize the appointment time for another patient.

FOR OUR PATIENTS WITH DENTAL INSURANCE

Here at Perfect Smile Dental Studio, we always do our best to help patients maximize their benefits. As a courtesy to all our insured patients, we will electronically file their insurance claims forms. The patient's claim will be filed immediately, and benefits are expected to be paid within 30 days. However, the filing of an insurance claim does not relieve the patient of a timely payment of their account. If the claim is not cleared by their carrier in 60 days, the unpaid portion will become the patient's responsibility and a statement will be issued for the unpaid portion. The patient is responsible for any amounts that their insurance company chooses not to pay.

We do not accept the assignment of benefits from secondary insurance carriers. We will walk the patient through the process of submission; however, payment will be due from the patient for the remaining balance after primary carrier has paid.

DEPOSIT POLICY

Due to the fact that we want to render the very best care to our patients, we require a deposit of a 1/3 of the treatment fee to make an appointment for procedures that are 90 minutes or more. A deposit is of the utmost necessity so that we can reserve the appointment specifically for each patient. The deposit also serves to respect all parties' time.

For patients with two insurances, the patient must pay a deposit **also**. We spend a great deal of time getting ready for the patient's visit. The patient does us **and** other patients a huge disservice by not showing up for their reserved time.

RETURNED CHECKS

There will be a \$25.00 charge for all returned checks. This charge **along** with any balance due will need to be collected *prior* to the patient's next office visit.

PAYMENTS

All payments for the patient's personal balance (cash visit fees, **deductibles** and co-payments) are due at the time of service or by authorized payment plan.

All accounts which become delinquent by more than 90 days may **be** sent to a collection agency for satisfaction.

In our office, we strive to maximize your insurance benefits and **make** any remaining balance more affordable. Dental treatment is an excellent investment in one's physical and psychological well-being.

Consent

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office **for myself or my dependents** is mine, due and payable at the time services are rendered

Signature: _____

Date: _____