HIGHLAND DENTAL CLINIC

Dr. Blanca Fernandez, DMD
5163 US HWY 98 South Lakeland, Florida 33812
Phone: 863-647-1954 • www.bfdentalclinic.net

PATIENT INFORMATION (PLEASE PRINT)

Patient Name: _____
Last First MI (Preferred Name)

(Circle One) Family Status: Single Married Child Gender: Male Female

Social Security #_____ - _____ - _____ Date of Birth_____/_____/_____

Mailing Address: _____
Street Lot/Apartment#

_____
City State Zip Code

Phone: (_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
Home Work Cell

E-mail Address: _____ Drivers License # _____

HEALTH INFORMATION

Have you ever had any of the follow? Please check those that apply.

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint/Valve
- ☐ Any metal pins, rods or screws anywhere in your body?
- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Erythromycin Allergy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A / B / C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Low Blood Pressure
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoke: Packs/Day _____
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Taking Blood Thinners
- ☐ Takes Pre-Medication
- ☐ Tetracycline Allergy
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other Allergies

_____
_____
_____
_____
_____

List any mediations you are currently taking: _____

Have you ever taken any of the following: (Check ALL that apply)

- ☐ Actonel
- ☐ Aredia
- ☐ Boniva
- ☐ Dridonel
- ☐ Fosamax
- ☐ Reclast
- ☐ Skelid
- ☐ Zometa

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Are you under the care of a physician? Yes No If yes, please explain: _____

Name of Physician: _____ Phone (_____) _____ - _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment, without fail.

_____
Patient's or Guardian's Signature Date

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? (Please list the name of the referral.)

☐ Another Patient: Friend/Relative ☐ Newspaper/Magazine ☐ Another Dental Office ☐ Insurance Company

☐ Yellow Pages ☐ School Name of person or office referring you to our practice: _____

RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ the responsible party

Name: _____
Last First MI

(Circle One) Family Status: Single Married Child Gender: Male Female

Social Security #_____ - _____ - _____ Date of Birth _____/_____/_____

Mailing Address: _____
Street Lot/Apartment#

_____
City State Zip Code

Phone: (_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
Home Work Cell

E-mail Address: _____ Drivers License # _____

EMPLOYMENT INFORMATION

The following is for: ☐ the patient's spouse ☐ the responsible party

Employer's Name: _____ Occupation: _____

Address: _____
Street City State Zip

INSURANCE INFORMATION

Insured's Name: _____ Is the insured a patient? Yes No
Last First

Insured's Date of Birth _____ / _____ /_____ Insurance ID# _____

Group # _____ Insurance Phone # (_____) _____ - _____

Employer's Name: _____ Occupation: _____

Address: _____
Street City State Zip

APPOINTMENT POLICIES/CONSENT FOR SERVICES

At Highland Dental Clinic we prefer to deserve specific time in our schedule for each patients's dental treatment. By scheduling this way, the doctor can focus and give the best treatment to each patient. To insure that our patients can be seen at their scheduled time, the following appointment policies have been established.

- ☐ Highland Dental Clinic requires a minimum of 48 hours notice to reschedule an appointment
- ☐ If the proper notice is not given to cancel an appointment, a fee of $25.00 will be assessed on your account for a broken appointment. This fee must be paid prior to scheduling any further appointments.
- ☐ Before treatment can be rendered adequate radiographs of the teeth and mouth must be taken.
- ☐ Unless otherwise arranged payment for services is due the day the treatment is rendered. With prior approval on certain extended procedures and treatment, payment plans can be arranged.

This is to certify that I, the undersigned, consent to the performing the dental and oral surgery procedures agreed to be necessary or advised including the use of local anesthetic as indicated. I also certify that I have read and understand the above. Any questions that I have regarding the form have been answered to my satisfaction. I will not hold Highland Dental Clinic responsible for any errors or omissions that I may have in the completion of this form.

I herby guarantee payment of any and all bills rendered for said patient which are not covered or allowable by insurance together with all collection costs, including attorney's fees for counsel in the event that it becomes necessary for Highland Dental Clinic to file suite for payment.

_____
Patient's or Guardian's Signature Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

HIGHLAND
DENTAL
CLINIC

Dental New Patient Survey

1. Is there a specific reason for your visit today?

2. How did you first hear about us?

3. How often do you make dentist visits?

4. Are you happy with the shade of your teeth?

5. What would be the most convenient days and hours for you to visit a dentist?