Suncoast Dentistry

Beautiful Smiles. Personal Care.

Welcome to our practice! We are very excited that you have chosen us for your dental care. We realize you have options in choosing a dental provider and we appreciate your trust and confidence in our practice!

At your first appointment, your doctor will complete a comprehensive oral examination. This includes a complete review of your medical and dental history, all necessary x-rays and intraoral photos, study models (if necessary), oral cancer screening, periodontal health evaluation, and examination of your teeth and soft tissues. Following this exam, your dentist will discuss their findings with you, develop a treatment plan that you are comfortable with, and then you will be scheduled according to your needs.

Please be prepared for your appointment by printing and completing the new patient registration forms. In order for our staff to be fully prepared for your visit, we ask that you either fax your completed forms to 941-894-1181 or e-mail to info@SuncoastDentistryParrish.com prior to your dental appointment. If you plan to bring the completed forms with you to your appointment, please arrive 15 minutes prior to your appointment to allow us to input your information. If you have dental insurance, be sure to provide all requested information prior to your appointment so we may verify coverage, check benefits, and be able to provide the most accurate estimates possible. Payment is expected at the time of visit. If you are covered by insurance, we will expect payment of your portion at the time of service unless prior arrangements are made. We also have several financing options available and will be happy to discuss all options with you.

We ask that you make every effort to keep your appointments. Missing an appointment disrupts proper sequencing of care and delays completion of your treatment. If you need to reschedule your appointment, please call us at least 24 hours prior to your visit.

Our practice realizes the importance of our patients and we value our patients and their referrals greatly. We are always excited to see new smiles coming through our door! We very much appreciate your confidence in us and look forward to seeing you soon!

Sincerely,

Dr. Joseph T. Vu & The Suncoast Dentistry Team

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Date:_____

Dr – Mr – Mrs – Ms – Miss Name: _____Preferred Name: _____

Male or Female DOB: _____/_____/_____ E-mail:_____

Address: _____City: _____State: _____ Zip: _____

Preferred phone: (_____)_____ [ ] Mobile [ ] Home [ ] Work

Alternate Phone: (_____)_____ [ ] Mobile [ ] Home [ ] Work

Emergency Contact: _____relationship:_____Phone: (_____)_____

Employer: _____ Work Phone: _____

RESPONSIBLE PARTY

Who is responsible for paying for your account? _____

Relationship to you: _____ Phone: (_____)_____

Address: _____

INSURANCE INFORMATION

Are you covered on DENTAL insurance? YES or NO Patient SSN # : _____-_____-_____

PRIMARY Dental Insurance:_____Ins Phone: (_____)_____

Subscriber Name: _____Subscriber DOB:_____ Subscriber SSN:_____-_____-_____

ID #:_____ Insurance group #:_____

Relationship to subscriber:_____ Employer providing ins. name:_____

SECONDARY Dental Insurance:_____Ins Phone: (_____)_____

Subscriber Name: _____Subscriber DOB:_____ Subscriber SSN:_____-_____-_____

ID #:_____ Insurance group #:_____

Relationship to subscriber:_____ Employer providing ins. name:_____

PREFERRED PHARMACY

Pharmacy Name: _____ Pharmacy Phone # (_____)_____

Pharmacy Address: _____

Thank you for your trust and confidence in our office!

Who shall we thank for referring you to our practice? _____

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HIPAA CONSENTS

Consent to the Use and Disclosure of Health Information for treatment, payment, or health operations.

I, _____(*patient name*) DOB ____/_____/_____ understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means for communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that Suncoast Dentistry reserves the right to change their notice and practices as necessary. Prior to implementation, we notify you of the revised notice and any changes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out our treatment, payment, or healthcare operations, and that Suncoast Dentistry is not required to agree to the restrictions requested.

_____I fully understand and ACCEPT the terms of this consent.
(Initial)

_____I acknowledge that I have received or have been offered a HIPAA privacy notice. A HIPA
(Initial)

Release of Information

_____I authorize the release of information including the diagnosis, medical and dental records, account,
(Initial) insurance, and claims information to:

[ ] Spouse _____ [ ] Other _____

[ ] Child(ren) _____

_____ Information may not be released to anyone.
(Initial)

Messages

If unable to reach me, you may leave a message at: [ ] Mobile Phone (_____) _____

[ ] Home Phone (_____)_____ [ ] Work Phone (_____)_____

I understand that I may revoke this consent in writing, except to the extent that Suncoast Dentistry has already acted in reliance thereon.

Signature:_____ Date:_____
Patient or Legal Guardian

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PATIENT HEALTH HISTORY

Patient Name_____ DOB _____/_____/_____Date_____/____/_____
In rendering proper dental care for you, it is important that we are informed about your health. Please answer all of the following questions. Thank you for your cooperation.

Overall Health: Excellent____ Good____ Fair____ Poor____ Date of last physical: _____/_____/_____
Medical Doctor: _____ Phone # (_____)_____
Address:_____
Current Medications (prescriptions or over the counter): _____
_____
_____
_____

Do you require antibiotics *prior* to dental procedures(PRE-medication)? YES or NO _____
Please check all symptoms or conditions that you have or have had in the past.

_____ **Artificial heart valve***	_____**History of endocarditis***	_____**Congenital heart defect***
_____**Heart pacemaker**	_____**Heart attack**	_____**Heart disease**
_____**Mitral Valve prolapse**	_____**Rheumatic fever**	_____**Artificial joint/hip**
_____**Pain in chest**	_____**Abnormal blood pressure**	_____**Stroke**
_____**Diabetes**	_____**Smoker? If yes, how much? _____**	

*Indicates conditions that may require pre-medication. If required, which antibiotic? _____

_____Hepatitis	_____HIV positive	_____Tuberculosis (TB)
_____Excessive bleed	_____Anemia	_____Blood Transfusion
_____Bruise easily	_____Aspirin therapy	_____Blood Thinners -Warfarin - Coumadin
_____Asthma or hay fever	_____Lung diseases or COPD	_____Kidney disease
_____Jaundice or liver disease	_____Cold sores or fever blisters	_____Ulcers
_____Arthritis	_____Epilepsy or Seizures	_____Fainting or dizzy spells
_____Lupus	_____Glaucoma (eye trouble)	_____Pregnant – if yes, due date: _____

_____Cancer – If yes, are you undergoing Radiation treatments? YES or NO Chemotherapy? YES or NO
If yes, who is your oncology doctor? Dr. _____ Phone # (_____)_____

DENTAL HISTORY

Last dental visit date:_____ [ ] Don't know [ ] 6 months [ ] within 1 year [ ] 1-3 years [ ] Never
Last dental x-ray date:_____ [ ] Don't know [ ] 6 months [ ] within 1 year [ ] 1-3 years [ ] Never

Have you ever been told you have Periodontal (Perio) disease? YES or NO – If yes, when? _____
Please check all that applies to you: [ ] Teeth Grinding/Clenching [ ] Pain in Jaw (TMJ) [ ] Sensitive Teeth
[ ] Use Tobacco Products. [ ] Broken/Loose Teeth [ ] Difficulty Chewing/Swallowing
[ ] Pain anywhere in mouth. [ ] Swollen/Bleeding Gums [ ] Wears Dentures [ ] Mouth Sores

How often do you brush your teeth? _____ floss your teeth? _____

MEDICATION HISTORY

Are you allergic to any medications or had an adverse reaction to any of the following? [ ] None [ ] Latex
[ ] Penicillin [ ]Amoxicillin [ ]Sulfa [ ]Tetracycline [ ]Codeine [ ]Aspirin [ ]Epinephrine
[ ]Novocain [ ]Metals [ ]Local Anesthetic [ ]Others _____

Signature of Patient or Guardian_____Date_____/_____/_____

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TREATMENT CONSENT

I, _____(Name) _____(DOB), hereby authorize Suncoast Dentistry and whomever they may designate as his/her assistants to perform upon me the following operations and/or procedures for dental treatment. If any unforeseen condition arises in the course of the designated operations and/or procedures calling in their judgment for procedures in addition to or different from those now contemplated, I further request and authorize him/her to do whatever he/she deems advisable.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used, and the consequences if this treatment were withheld. I am informed fully and understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, and loss or loosening dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissue, nerve disturbances (e.g. numbness in mouth and lip tissues, jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions), cardiac arrest, aspiration and thrombophlebitis (e.g. irritation and swelling of a vein), discomfort, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.

I realize that in spite of the possible complications, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the operation/procedure(s). I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed, and permit prescribed diagnostic procedures.

I hereby authorize Suncoast Dentistry to use photographs of my case for presentation to other patients, students and staff for the purpose of education and information. I understand that only pictures of my teeth, not my entire face, will be used for this purpose.

_____ _____

Signature of Patient or Guardian **Today's Date**

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Patient Information and Agreements

Suncoast Dentistry is committed to providing all patients with exceptional service and care. Dentistry is not an exact science and therefore reputable practitioners cannot fully guarantee results. I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. All patients are given a treatment plan following examination and must agree to the treatment plan prior to beginning any procedure(s).

Treatment Plan Estimates and Dental Insurance Benefits

Suncoast Dentistry will provide you with a good faith *ESTIMATE* of the costs of procedures. The Treatment Plan is simply a good-faith attempt to predict the cost of your treatment based on the facts known to Suncoast Dentistry when the estimate is made. During treatment, it may be necessary to change or add procedures because of conditions found that were not discovered during the examination. If you have dental insurance, it is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan. Your Treatment Plan Estimate of insurance benefits is based on information provided to us by *YOUR* insurance company and by you. It is simply just an E*STIMATE* and your insurance benefits may be higher or lower than estimated. In all cases, you are responsible for amounts not covered by your insurance. Your insurance is a contract between you, your employer, and the insurance company. We encourage you to contact your insurance or employer if you have specific questions about coverage.

Predetermination of Insurance Benefits

A Predetermination of Benefits is a process whereby your insurance company or plan administrator tells you in advance of treatment what procedures may be covered by your insurance plan, the amount the insurance company may pay toward those procedures, and the amount you may be required to pay. It is like submitting a claim before the dental procedure or service has taken place. Because the Predetermination comes directly from your insurer, the risk of error as to your coverage is reduced. Although helpful, your insurer will inform you that a Predetermination of Benefits is *not a guarantee of coverage*. The Predetermination may not consider, for example, a prior claim submitted by another dentist for services provided to you, changes in your coverage that occur after the Predetermination is made but before the services actually are provided, or the insurance company's subsequent opinion that a condition could have been treated by a less costly alternative to the service provided by your dentist. The time it takes to receive a Predetermination from your insurance company or plan administrator can vary, from as few as two weeks to as many as eight weeks.

Dental Insurance Communication and Payment Authorization

I hereby authorize payment from my insurance company directly to Suncoast Dentistry. I understand that I am responsible for all costs of dental treatment not covered by my insurance. I authorize Suncoast Dentistry to speak to my insurance company on my behalf and release of information relating to my claim.

Financial Policy

Suncoast Dentistry patients agree to the following payment policies:

- Payment in full of the estimated patient portion of the fees is due no later than when services are rendered.
- For comprehensive treatment plans requiring multiple office visits, Suncoast Dentistry requires a minimum deposit of 50% of the total estimated patient portion of the fees at the start of treatment.
- Patients are always responsible for amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit.
- Patients may, at their discretion, elect to pay in full, in advance for comprehensive treatment plans.
- Returned checks are subject to a $30.00 fee. Balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½ % per month.
- ***A $30.00 charge will be assessed for broken appointments and appointments cancelled without 24-business hours.***

Treatment Cancellation and Interrupted Services Charges

Patients requiring crown or bridge services may cancel treatment with no charge prior to natural teeth being prepared or altered for the prosthetic. Once tooth preparation occurs, patients are liable for the estimated full cost of the services even if they choose not to complete treatment.

Accepted Forms of Payment

Suncoast Dentistry accepts cash, personal checks, Visa, MasterCard, assigned insurance benefits, and approved third-party financing.

Signature of Patient or legal guardian: _____Date: _____