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:

- ☐ ADD/ADHD/Autism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer______________
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ NO EPI
- ☐ Other______________
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Pre Med
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ 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: ________________