Justine Chase, D.D.S.
Jordan Harper, D.M.D.
850-897-4200

Patient Information

Date:_____ Patient's Name: _____

○ Male ○ Female Date of Birth: _____

Address: _____ Home Number: _____

City: _____ State: ____ Zip Code: _____ Work Number: _____

○ Minor ○ Married ○ Single Cell Number: _____

Social Security Number: _____ Email: _____

Place of Employment: _____ Which Confirmation Methods do you Prefer?

☐ Phone ☐ Text ☐ Email

Who may we thank for

referring you to our office:? _____

Primary Dental Insurance: _____ Subscriber #: _____ Group #: _____

Secondary Dental Insurance: _____ Subscriber #: _____ Group #: _____

Family Information

Fill in both blocks for minor child. Fill in appropriate block for adult.

Father Husband DOB:_____

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Home #: _____ Work #: _____

Cell #: _____ SS #: _____

Employer: _____

Dental Ins: _____

Subscriber #: _____

☐ Mother ☐ Wife DOB: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____ SS #: _____

Employer: _____

Dental Ins: _____

Subscriber #: _____

Person Responsible For Account ☐ Patient ☐ Guardian ☐ Father ☐ Mother

Name of Person Responsible For Account: _____

Emergency Contact Name: _____ Phone # :_____

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information provided on all forms are correct to the best of my knowledge. I grant the right to the Dental Office to release dental/medical information including diagnostic records and photographs to third party payors or other health care professionals in consultation or as educational material.

Name of Patient,
Parent or Guardian: _____ Signature: _____

○

MID BAY DENTAL
FAMILY DENTISTRY

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Health History

Name: _____ Date: _____

Do you have or have you had any of the following? Please check "YES" or "NO".

Heart Problems:

High or Low Blood Pressure	○ YES	○ NO
Heart Murmur or Mitral Valve Prolapse	○ YES	○ NO
Artificial Valve, Pacemaker or Stent	○ YES	○ NO
Arteriosclerosis	○ YES	○ NO
Heart Attack or Angina Pectoris	○ YES	○ NO
Heart Medications or Nitroglycerin	○ YES	○ NO

Blood Problems:

Easy Bruising	○ YES	○ NO
Abnormal Bleeding	○ YES	○ NO
Blood Thinners(Coumadin, Plavix or Aspirin)..	○ YES	○ NO
Circulatory Problems	○ YES	○ NO
Hemophilia	○ YES	○ NO
Low Blood Sugar or Anemia	○ YES	○ NO

Respiratory Problems:

Asthma, Emphysema or Tuberculosis	○ YES	○ NO
Chronic Bronchitis	○ YES	○ NO
Sinus Troubles	○ YES	○ NO
Frequent or Severe Headaches	○ YES	○ NO
Fainting Spells, Seizures or Epilepsy	○ YES	○ NO

Bone or Joint Problems:

Joint Replacement (Hip, Pins, Plates, etc)	○ YES	○ NO
Implants	○ YES	○ NO
Arthritis or Osteoporosis	○ YES	○ NO
Taking Bisphosphonates (Fosamax, Boniva)..	○ YES	○ NO
Taking Corticosteroids	○ YES	○ NO
Cancer (Chemotherapy or Radiation)	○ YES	○ NO
Tumors or Benign Growths	○ YES	○ NO

Allergic Reactions:

Aspirin, Acetaminophen, or Ibuprofen	○ YES	○ NO
Codeine or Other Narcotics	○ YES	○ NO
Dental Anesthetic	○ YES	○ NO
Sensitivity to Epinephrine (Vasoconstrictor)..	○ YES	○ NO
Antibiotics (Penicillin or Other)	○ YES	○ NO
Sedatives (Valium) or Sleeping Pills	○ YES	○ NO
Latex (Allergy or Sensitivity)	○ YES	○ NO

Other:

_____

Diabetes	○ YES	○ NO
Any Physical Limitations	○ YES	○ NO
Hearing or Sight Disability	○ YES	○ NO
Glaucoma or Contact Lenses	○ YES	○ NO
Psychiatric Treatment	○ YES	○ NO
Depression or Anxiety Disorder	○ YES	○ NO
HIV or Aids	○ YES	○ NO
Hepatitis A, B or C	○ YES	○ NO
Liver or Kidney Issues	○ YES	○ NO
Drug or Alcohol Abuse Issues	○ YES	○ NO
Smoke or Chew Tobacco	○ YES	○ NO

Women

Are you pregnant?	○ YES	○ NO
Taking Hormones or Contraception?	○ YES	○ NO

Do you require "Premedication" with an antibiotic prior to dental treatment?	○ YES	○ NO
Snoring	○ YES	○ NO
Sleep Apnea/ CPAP	○ YES	○ NO
GERD/Acid Reflux	○ YES	○ NO

Health Issues we should know about?:

Name of Patient,
Parent or Guardian: _____ Signature: _____

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Dental History

Patient's Name: _____ Date: _____

What is your estimate of your dental health? ○ Good ○ Fair ○ Poor

What specific dental concerns do you have now? _____

How long ago was your last dental visit?
And what was the treatment? _____

Please mark any questions that you would answer "YES".

- ☐ Are you here today because of an emergency?
- ☐ Are you interested in "Comprehensive" care?
- ☐ Are you apprehensive about dental care?
- ☐ Have you had problems with previous dental treatment?

- ☐ Do you have sore, tender or bleeding gums?
- ☐ Have you had gingivitis or periodontal disease?
- ☐ Do you have your teeth cleaned more than twice a year?
- ☐ Have you seen a periodontal specialist for treatment?

- ☐ Are your teeth sensitive? And to what? (Check below)
  - ☐ Hot or cold foods/liquids?
  - ☐ Biting?
  - ☐ Other?

- ☐ Are you missing teeth other than wisdom teeth?
- ☐ Do you wear partials or dentures?
- ☐ Do you have any dental implants?
- ☐ Does food catch in your teeth? Any loose teeth?

- ☐ Have you had orthodontics?
  - ☐ Still wearing retainers?
- ☐ Do you clench or grind your teeth frequently?
- ☐ Do you wear a nightguard/ biteguard?
- ☐ Do you wear a sports guard when playing sports?

- ☐ Have you been diagnosed with a Tempormandibular (jaw) Disorder (TMJ or TMD)?
- ☐ Do you have headaches or jaw symptoms on wakening?
- ☐ Do you have pain in your face, jaw joint, neck or temples?
- ☐ Have you had any jaw or facial trauma?

- ☐ Is there anything you would change about your teeth?
  - ☐ Color?
  - ☐ Shape?
  - ☐ Spaces?
  - ☐ Alignment?
  - ☐ Other?

How often do you brush and floss? _____

What statement best describes the treatment you are seeking?

- ☐ Just want to avoid pain.
- ☐ Want to keep my teeth functional and healthy.
- ☐ Want to keep my teeth functional, healthy and good looking.

Anything else we should know? _____

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NOTICE OF PRIVACY PRACTICES SUMMARY (HIPAA)

This summary discloses how Healthcare information about you may be used by our office. A full notice of your privacy rights has been provided to you.

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public health, research, health and safety, government, works compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Complaints. You may complain to our Office Manager at 850-897-4200 or to the Department of Health and Human resources if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Questions. If you have any questions, please contact our Office Manager at 850-897-4200.

I acknowledge that I have received the full Privacy Notice.

Name of Patient,
Parent or Guardian:_____

Signature:_____ Date:_____

For office use:

○ Patient refused to sign.

○ Patient unable to sign.

○ Other :

_____

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FINANCIAL POLICY

Our primary concern is for your health. For your convenience, listed below are the options available to address your financial needs.

To our insured patients: As a courtesy to you, we will be happy to review your plan to determine how your insurance can "reimburse" you for a portion of your dental costs, and maximize your insurance benefits. We accept many insurance plans. Please remember no insurance company attempts to cover 100% of all dental cost. It is your responsibility to pay any deductible or any balance not paid by your insurance carrier.

***Payment in full is expected at the time of service.**

***All patient portions are due at the time of service unless other arrangements have been made previously with our financial coordinator.**

We work hard to make ideal dental care affordable for our patients. For your convenience we accept Cash, Check, Master Card, Visa and we offer Care Credit to help create payment plans that suit different budgets. Patients in need of a payment plan must make arrangements with our financial coordinator.

Accounts over ninety (90) days will be considered past due, and assessed a finance charge of 1% per month.

Please let us know 48 hours in advance if you need to make a change to the time reserved for you with the doctor or hygienist. **We reserve the right to charge for missed appointments or appointments cancelled with less than a 48 hour notice**. The fee is **25.00 dollars per appointment hour** missed.

By signing below; You agree that you are responsible for all costs of dental treatment for yourself and your dependents. You agree to the above financial policy and will abide by terms.

Name of Patient,
Parent or Guardian: _____ Date: _____

Signature: _____

THANK YOU FOR YOUR CONSIDERATION