Prosperity Dental Group
1535 Prosperity Farms Road - Lake Park, Florida 33403

PATIENT REGISTRATION

Today's Date: _____

Patient's Name	**Sex: M F**	**Birthdate**	**Age**
Home Address	**City**	**State**	**Zip**
***Please Circle One*: Married Single Separated Widow**		**Your Soc. Sec. #**	
Home Ph#	**Cell Ph#**	**Email Address**	
Your Employer		**Work Ph.#**	**How Long Employed**
Are you full time student? ☐ Yes ☐ No	***If patient is minor we need:***	**Mother's DOB**	**Father's DOB**
Person responsible For account		**Driver's License**	**Relationship**
Name of Spouse (parent if minor)		**Spouse's (parent's) Soc. Sec. #**	
Spouse's (parent's) Employer		**Work Ph.#**	**Cell Ph.#**
EMERGENCY INFORMATION ***Name, address & telephone of a relative not living with you***			
Reason for this visit			
How did you hear About our office?			

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment Is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please check If you would like more information about financing options. ☐

Please Note: **Returned checks will be subject to additional fees. In the case, it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.**

Do You Have Insurance?

- **As a courtesy to you we will help you process all your Insurance claims. Please understand that we will provide an insurance estimate to you, however It is not a guarantee that your insurance will pay exactly as estimated. Your Insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate Is as accurate as possible.**
- **All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care providedr, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office Is not a party to that contract.**
- **Our practice Is committed to providing the best treatment for our patients and we charge what Is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**
- **We ask that you sign this form and/or any other necessary documents that may be required by your Insurance company. This form Instructs your insurance company to make payment directly 10 our office.**
- **We ask that you pay the deductible and co-payment, which Is the estimated amount not covered by your insurance company, by cash, check, MasterCard. Visa, or Discover at the time we provide the service to you.**
- **Insurance payments are ordinarily received within 30-60 days from the time of filing. If your Insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment Is expected. If payment Is not received or your claim Is denied, you will be responsible for paying the full amount at that time.**
- **We will cooperate fully with the regulations and requests of your Insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.**

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.
***TREATMENT PLANS ARE ONLY VALID FOR 30 DAYS**

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AN 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 unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.
By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an Incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent if child) **Date**

Patient Name: _____

DENTAL HISTORY

Please check any of the following problems that apply to you.	Yes	No
-Sensitivity (hot, cold sweet pressure)	☐	☐
Where? UR LR UL LL		
- Headaches. caraches, neck pain	☐	☐
- Jaw joint pain	☐	☐
- Teeth or fillings breaking	☐	☐
- Grinding or clenching teeth	☐	☐
- Bleeding, swollen or irritated gums	☐	☐
- Loose, tipped or shifting teeth	☐	☐
- Bad breath		
Do you have or have you had any of the following?		
- Dentures	☐	☐
- Partial dentures	☐	☐
- Braces	☐	☐
- Periodontal (gum) treatments	☐	☐

If you could whiten your teeth for a cost anyone could afford, would you do ix?	Yes	No
Do you smoke or use chewing tobacco?	☐	☐
How much? _____For how long?_____		
If I could change my smile,I would:		
- Make it whiter	☐	☐
- Make it straighter	☐	☐
- Close spaces	☐	☐
- Replace black metal fillings with tooth colored restoration	☐	☐
- Repaired chipped teeth	☐	☐
- Replace missing teeth	☐	☐
- Replace old crowns that don't match	☐	☐
- Have a smile makeover	☐	☐

Please share the following dates:

- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Number of Previous Dentist _____

City _____ State _____

Phone number _____

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

_____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following problems / conditions that apply to you:

	Yes	No
AIDS	☐	☐
Allexgies (Seasonal)	☐	☐
Anemia	☐	☐
Angina (Chest pain)	☐	☐
Arthritis	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joints	☐	☐
Asthma	☐	☐
Blood Disease	☐	☐
Bruise Easily Cancer	☐	☐
Cervical Cancer	☐	☐
Chemotherapy	☐	☐
Cortisone Medication	☐	☐
Diabetes	☐	☐

	Yes	No
Dizziness	☐	☐
Drug Addiction	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Excessive Blending	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Heart Conditions	☐	☐
Heart Lesions (Congenital)	☐	☐
Heart Murmur	☐	☐
Heart Sugar	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
High Blood Pressure	☐	☐

	Yes	No
HIV Positive		
HPV		
Jaundice		
Jaw Joint Pain		
Kidney Disease		
Liver Disease		
Low Blood Pressure		
Mitral Valve Prolapse		
Nervousness/Depression		
Pacemaker		
Pregnant Currently		
Radiation (head/neck)		
Respiratory Problems		
Rheumatic Fever		
Rheumatism		

	Yes	No
Scarlet Fever		
Seizures		
Sinus Problems		
Sleep Apnea		
Stomach Problems		
Stroke		
Thyroid Disease		
Tuberculosis		
Ulcers		
Venereal Diseases		
Other_____		

Are you allergic or have you reacted adversely to any of the following medications?

	Yes	No		Yes	No		Yes	No		Yes	No	Other_____
Aspirin			Percodan			Tetracycline			Valium			
Darvon			Latex			Codeine			Penicillin			
Nitrous Oxide			Local Anesthetic			Erythromycin			Sulla			

Have you ever taken any the following medications?

	Yes	No		Yes	No
Actonel			Zometa		
Aredia			Boniva		
Fosamax			Herbal		
Reclast			Supplements		

Are you under a physician's care? What for?

_____

What medications are currently taking?

_____

Family Physician Phone Number

Consent:

The undersigned herby authorizes Doctor to take X-Rays, study models, photographs, or any other diagnostic aids appropriate by Doctor to make a through diagnostics of the patient dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. i also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

{Patient Signature} **{Date}** **{Dentist Signature}**

Prosperity Dental Group
1535 Prosperity Farms Road Lake Park, Florida 33403
(561) 848-0087

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	{Relationship}
_____	_____
{Please Print Name}	{Relationship}
_____	_____
{Please Print Name}	{Relationship}

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign
Communications barriers prohibited chaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify)

_____

_____

Prosperity Dental Group
1535 Prosperity Farms Road Lake Park, Florida 33403
(561) 848-0087

Financial Policy

Our philosophy is to make patients lives healthier and more comfortable by providing high quality, compassionate dental care at an affordable price.

Financing

We have several financial policy options available for your convenience to receive proper dental care.We have found that our patients appreciate knowing exactly what dental financial responsibilities they will incur.Therefore, we inform our patients about our financial policies before we begin treatment. Knowing this ahead of time allows us all to arrange for the completion of the necessary dental treatment.

Dental insurance Financing

Most insurance companies will not cover 100% of all dental expenses. Your portion, not covered by insurance, is due at the time treatment is performed. Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. The patient is still the responsible party regarding dental fees. We will be glad to process your insurance forms at no charge. Please be aware that we are only capable of approximating your portion due to the large number of insurance companies and to their periodic changes within their contracts without notifying each dental office of these changes.

Gradual Treatment Plan

If it will be easier financially for those patients without dental insurance, we can plan the completion of your dental work by spreading your appointments over several months or years. We will arrange to do the more urgent services at the beginning of treatment.

Special financing

Our office also works with CareCredit, a dental finance company, to assist you with your payment. For qualified applicants, interest-free payments can be spread over at three , six month period. Finance company approval must be obtained prior to starting your treatment. Extended payment plans are also available at a low interest rate up to 5years.

Prosperity DentalGroup **HAS NO REFUND POLICY.**

_____ _____

{Patient Signature} {Date}

Prosperity Dental Group
1535 Prosperity Farms Road Lake Park, Florida 33403
(561) 848-0087

Every effort is made to keep us on schedule so we respectfully ask patients to be prompt and keep their appointments.

Our standard office policy regarding appointments is as follows:

We try to remind patients via text, phone and mail prior to appointments, but **PLEASE DO NOT** depend on this courtesy. If we unable to reach you, your appointment card will serve as confirmation of your appointments and implies your obligation to be present.

That appointment date and time has been reserved specially for you. We reserve the right to charge for office visit for cancelled or broken appointments without 24 hours advance notice. The 1st broken appointment fee is $30. Surgeries must be cancelled with 5 day notice. Broken appointment for surgery will be charged accordingly to the extension of the appointment. Exceptions to the policy can be determine only on an individual basis according to the circumstances.

If you have any questions about this policy, do not hesitate to ask any member of our staff. They will be glad to answer your questions. We believe that good communications is the key to excellence in the care of your dental health.

Thank you for your cooperation,

Dr. Anna Royzman
Prosperity Dental Group

_____ _____
{Signature} {Date}