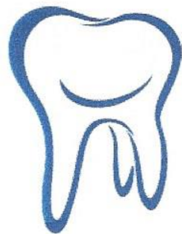

SMILE by FAULKNER
smile artistry • general denistry

Patient Information

Patient Name: ____ Date:______________
Last First MI Preferred
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Birthdate: ______/____/______SS#:_______-_____-________Driver's License #:______________________

Address: ____
Street Apartment #

____
City State Zip Code

E-Mail______________________________________Home# ( )______-________Work#( )_____-
_______Ext:_________

Best time to call?_________Cell#( )______-_______Fax#( )_______-______Other#'s( )______-________

Insurance / Employer Information

Primary Insurance

Name of Insured:____Birthdate:______/_______/_______
Last First MI

SS#: ________________Group #__________________ Employer Name:______________________________

Insurance Plan Name and Address: ____
____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other________________________

Consent for Services

This practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that it is only a benefit and that He/She is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

If payment from your insurance company is not paid within 30 days, account unpaid balance will be your responsibility, unless previously written financial arrangements are made. Once insurance payment is made, reimbursement will be sent directly to the patient within 4 weeks.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ______________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

Health Information

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Date of Last Dental Visit: ____________________ Reason for today's visit:____________________________

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Question	Answer	
Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X______________________________ Date:__________

Patient Financial Responsibility
For Dental Care

As a patient of the office of Dr. Faulkner's, I understand that as a recipient of dental treatment, I, the undersigned, am responsible to Wayne L. Faulkner, D.D.S. for all charges not covered by my insurance, including co-payments, deductibles and fees for non-covered services. I understand that my insurance policy is a contract between me and my insurance company and I have the primary duty and obligation to pay my dentist for services rendered. **I agree that if I do not have insurance or my insurance company is not contracted by your office, full payment is due at the time of service.**

Any balance remaining on the account after insurance pays will be due upon receipt of my statement. I understand that if payment is not made, that Wayne L. Faulkner, D.D.S. may take action to collect its fees. I agree to pay all costs incurred by Wayne L. Faulkner, D.D.S. for collecting its fees, including an additional thirty-three and a third percent (33 1/3%) of the unpaid balance.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Provide the Dental office with complete and accurate billing information, including current insurance card.
2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit.

I HAVE READ AND AGREE TO ALL THE TERMS OUTLINED ABOVE

SIGNED (patient or guarantor):______________________________Date:_______

FOR (print patient name):____

Wayne L. Faulkner, DDS
6320 Venture Dr., Ste 102,103
Lakewood Ranch, Florida 34202
(941)907-1199

Wayne Faulkner, D.D.S
Juergen Lafrenz, D.D.S
6320 Venture Dr St. 102
Lakewood Ranch, Fl. 34202

HIPAA CONSENT FORM

Patient's name____________________________

HIPAA-Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how our Dental office may use or disclose your health care information; The Notice also explains the rights that you are guaranteed under HIPAA regulations.
Though our Practice has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy rule to distribute this notice to you and obtain acknowledgment that you have received the notice.
Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer.

Permission to Bill my Insurance Company/Financial Institution

All professional services rendered are charged to the patient. Necessary forms will be completed by our Practice to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.
I understand my signature authorizes releasing of the information to the insurer or agency given to our Practice for participating Dental insurance plans.
I am allowing my financial information (check, credit card, etc.) to be utilized to pay for Services rendered by the Practice.

Permission to share Medical/Dental Information

Please list any individual we are able to discuss your Dental, Medical and Financial information including Spouses, Children, Parents...Etc.:

________________________ ________________________

________________________ ________________________

Yes / No I give permission to have messages left on my Home phone

Yes / No I give permission to have messages left on my cell phone

Yes / No I give permission to have emails sent to my provided email address

______________________________ ______________

Signature of Patient or Guardian **Date**