Arena Dental STUDIO

ARENA DENTAL STUDIO

P:(954) 739-3810 F:(954) 368-3962
333 NW 70th Avenue Ste #104, Plantation, FL 33317
arenadentalstudio@gmail.com | www.arenadentalstudio.com

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have questions or need assistance, please ask us, we will be happy to help.

Date:_____
Patient #:_____

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Birth date _____ S.S. #_____
Home phone _____ Cell phone _____E-mail _____
Address _____City _____State _____ Zip_____
Check appropiate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or parent's employer _____ Work phone _____
Business address_____City _____State _____ Zip_____
Spouse or parent's name _____Employer _____Work phone _____
If patient is a student, name of school/college _____City _____ State _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone: _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Driver's license # _____ Birthdate _____Financial institution_____
Employer _____ Work phone _____
Is this person currently a patient in our office? Yes ☐ No ☐

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____Social security # _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City: _____ State: _____Zip:_____
Insurance company _____ Group # _____ Union or local #_____
Ins co. address _____ City _____ State _____Zip_____
How much is your deductible? _____ How much have you used?_____Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____
Birthdate _____Social security # _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State _____Zip_____
Insurance company _____ Group # _____ Union or local #_____
Ins co. address _____ City _____ State _____Zip_____
How much is your deductible? _____ How much have you used?_____Max. annual benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If Yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Are you allergic to or have you had any reaction to the following?	Yes	No
Local Anesthetics (eg. novacaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

9. Women Only:	Yes	No
a) Are you pregnant or think you might be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Heart disease	☐	☐	Chest pains	☐	☐
Heart attack	☐	☐	Cardiac pacemaker	☐	☐	Easily winded	☐	☐
Rheumatic fever	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Swollen ankles	☐	☐	Angina	☐	☐	Hay fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation therapy	☐	☐
Low blood pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent weight loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver disease	☐	☐
Diabetes	☐	☐	Joint replacement or implant	☐	☐	Heart trouble	☐	☐
Kidney diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory problems	☐	☐
AIDS or HIV infection	☐	☐	Sexualty transmitted disease	☐	☐	Other	☐	☐
Thyroid problem	☐	☐	Stomach troubles / Ulcers	☐	☐			

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain on any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instructions on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnostics and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize to takes pictures and videos for scientific and marketing purposes. **Yes** ☐ **No** ☐

X _____

Signature of patient or parent if minor

Doctor's Comments _____

_____

Signature _____ Date _____

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FINANCIAL POLICY

In an effort to keep fees reasonable, and to continue to provide quality care, we have established a payment policy. By executing this agreement you are agreeing to pay for all services that are received.

Payments: Our administrative Team will work with you to handle your financial needs, however we do require all routine treatment paid in full at the time of the service. If a financial contract is signed, payment is expected on the agreed due date, outlined in the contract. If a payment billing arrangement is made, the balance of your account is due and payable when the statement is issued, and is past due if not paid within 30 days.

Forms of Payments: Cash, Check and Credit Cards are all acceptable forms of payments. We accept MasterCard, Visa, American Express and Discover. In addition, we also offer third party financing, with processing taking only a few minutes. This is especially convenient if you will be having a comprehensive treatment plan.

Insurance: The financial coordinator will help you and your individual needs. If you have insurance benefits, we can provide an ESTIMATE of what your insurance company is expected to pay, but can make no guarantee of estimated coverage. All charges are your responsibility from the date services are rendered.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your debt to a collection agency, you agree to pay additional collection costs incurred from address searches, credit reports or attorney fees which·can possibly equal 50% of the balance due. We may also take the claim to Small Claims Court. You agree to pay any court fees incurred in trying to collect the past due balance.

Returned Checks: There is a fee for any checks returned by the bank. The fee's can range from $25-$40 depending of the amount of the check written. We prefer payment in cash on accounts with a history of a returned check.

Missed Appointment Fee: The second time a patient does not show up for an appointment, or cancels with less than 24 hours notice, we have the right to charge a $20.00 fee. Extenuating circumstances will be considered. This fee must be paid before a new appointment may be made.

Divorce: In case of divorce or ·separation, the party responsible for the account prior to the divorce or separation, remains responsible for the account. After a divorce or separation, the parent authorizing treatment (signing consents) for a child will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is authorizing parent's responsibility to collect from the other parent.

I have read and understand the financial policy outlined above.

Patient's Name _____ Responsible Party _____

Relationship to Patient _____ Signature _____ Date _____ / _____ / _____

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I hereby consent to the use and disclosure of my health information for the purposes and the activities under the federal privacy law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling.

_____ _____ / _____ / _____

Patient's Name (Please Print) Date

_____

Signature (If minor, Parent or Guardian)

_____

Patient's Legal Representative (If applicable)

_____ _____ / _____ / _____

Signature of Legal Representative Date

FOR DENTAL OFFICE USE ONLY

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

___ Individual refused to sign
___ Communication barriers prohibited obtaining the ACKNOWLEDGEMENT
___ An emergency situation prevented us from obtaining ACKNOWLEDGEMENT
___ Other, (Please Specify) _____

_____

Protecting Your Confidential Health Information is Important to Us

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information, and only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Print Name(s): _____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing your again soon!

Patient signature _____

Date _____

Patients Rights

The law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make ever y effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete.We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Please let us know in writing the time period for which you are interested. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail, or email a copy to you.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

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PATIENT'S COMUNICATION METHOD

PATIENT'S NAME: _____

HOME PHONE NUMBER:___(_____)_____

CELL PHONE NUMBER: ___(_____)_____

WORK PHONE NUMBER:___(_____)_____

EMAIL ADDRESS:_____

To serve you better, we would like for you to select your appointment confirmation preference. Please check the appropriate form of confirmation desired.

- ☐ HOME PHONE NUMBER
- ☐ CELL PHONE NUMBER
- ☐ WORK PHONE NUMBER
- ☐ TEXT MESSAGE
- ☐ EMAIL ADDRESS
- ☐ NONE OF THESE OPTIONS

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM
*CONSENTIMIENTO DE CORREO ELECTRÓNICO/MENSAJES DE TEXTO A MÓVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. ARENA DENTAL STUDIO., (ADS) offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. ADS will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, ADS cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between ADS and me and consent to the conditions outlined herein. Any questions I may have had were.

*Propósito: Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. ARENA DENTAL STUDIO, (ADS) ofrece a sus pacientes la opo tunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. ADS usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, ADS no podrá garantizarle proteger confidencial y seguro la comun cación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre ADS y yo consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me ha sido respondida.

Patient signature / Firma del paciente _____

Date / Fecha _____

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PATIENT'S NAME: _____

WHAT DO YOU THINK ABOUT YOUR SMILE?

Are you completely satisfied with the cosmetic appearance of your teeth? If not, what concerns do you have?

_____

_____

Which of the following would you change if it could be done easily and pain free?

- ☐ Teeth Color
- ☐ Tooth Shape
- ☐ Spaces between teeth
- ☐ Alignment of teeth
- ☐ Size of Teeth
- ☐ General overall appearance of smile

HOW DID YOU HEAR ABOUT US?

- ☐ Family or Friend- Name Please: _____
- ☐ Care to Share
- ☐ Social Media - Facebook or Instagram
- ☐ Our Website www.arenadentalstudiocom
- ☐ Google
- ☐ Zoc Doc
- ☐ Demandforce
- ☐ Insurance Company
- ☐ Other: _____