PATIENT INFORMATION

Patient's Name_____ Nickname_____

Address_____
STREET CITY STATE ZIP

Social Security #_____ Birthdate_____Home Phone_____

Cell Phone_____

Employer _____Occupation_____Work Phone_____

Parent or Guardian (if patient is a minor) _____

PERSON RESPONSIBLE FOR PAYMENT

Name_____ Relationship_____

Address_____
STREET CITY STATE ZIP

Social Security #_____ Birthdate_____Relationship to patient_____

Employer _____Occupation_____

DENTAL INSURANCE

Insured's Name_____SS#_____

Employer_____Work Phone_____

Employer's Address_____Contact Person_____

Insurance Company_____ Group #_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

INFORMATION AND CONSENT

I hereby authorize doctor to take x-rays or other diagnostic aids deemed appropriate 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 or other medicines as necessary. I fully understand that dental treatment and anesthetic agents embody certain risks and that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other financial arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account.

Patient (Guardian) Signature_____Date_____

REGISTRATION

All information is completely confidential

NAME_____DATE_____

1. PHYSICIAN'S NAME_____CITY_____PHONE_____

2. ARE YOU TAKING ANY MEDICINES OR DRUGS? YES NO PLEASE LIST_____

_____

3. ARE YOU ALLERGIC TO ANY MEDICINES OR DRUGS? YES NO PLEASE LIST_____

_____

4. HAVE YOU EVER TAKEN BONE LOSS PREVENTION DRUGS SUCH AS FOSOMAX, ACTONEL, BONIVA OR OTHER BISPHOSPHONATES? YES NO IF YES, PLEASE LIST NAME AND DOSAGE_____

_____

5. HAVE YOU BEEN A PATIENT IN THE HOSPITAL DURING THE LAST TWO YEARS? YES NO

6. DO YOU HAVE A HISTORY OF CHEMICAL DEPENDENCY? YES NO

7. HAVE YOU HAD OR DO YOU HAVE AT PRESENT THE FOLLOWING. **CIRCLE "YES" OR "NO" FOR EACH ITEM.**

HISTORY OF ENDOCARDITIS……	YES	NO	CHRONIC COUGH……	YES	NO
CONGENITAL HEART DISEASE(CHD)….	YES	NO	TUBERCULOSIS……	YES	NO
ORGAN TRANSPLANT……	YES	NO	ASTHMA……..	YES	NO
RENAL DIALYSIS……..	YES	NO	LATEX ALLERGY……	YES	NO
HEART (SURGERY,DISEASE,ATTACK)….	YES	NO	DRUG ALLERGY……	YES	NO
ARTIFICIAL HEART VALVE……..	YES	NO	CANCER……..	YES	NO
HIGH/LOW BLOOD PRESSURE……	YES	NO	RADIATION THERAPY……..	YES	NO
HEART PACEMAKER……..	YES	NO	CHEMOTHERAPY……..	YES	NO
STROKE…….	YES	NO	HEPATITIS……	YES	NO
ARTHRITIS…….	YES	NO	VENEREAL DISEASE OR STD…….	YES	NO
ARTIFICIAL JOINT REPLACEMENT……..	YES	NO	A.I.D.S./H.I.V. POSITIVE……	YES	NO
KIDNEY DISEASE…….	YES	NO	HEMOPHILIA……..	YES	NO
ULCERS…….	YES	NO	SICKLE CELL DISEASE……	YES	NO
DIABETES……..	YES	NO	LIVER DISEASE……..	YES	NO
THYROID PROBLEMS……	YES	NO	NEUROLOGICAL DISORDER……..	YES	NO
GLAUCOMA……..	YES	NO	EPILEPSY OR SEIZURES……	YES	NO
EMPHYSEMA……	YES	NO	FAINTING OR DIZZY SPELLS……..	YES	NO
COLD SORES/FEVER BLISTERS……..	YES	NO	PSYCHIATRIC CARE……..	YES	NO

8. LIST ANY DISEASE, CONDITION, PROBLEM NOT LISTED ABOVE_____

_____

9. WOMEN: ARE YOU **PREGNANT?** YES NO **NURSING?** YES NO **TAKING BIRTH CONTROL PILLS?** YES NO

10. PERSON TO NOTIFY IN CASE OF AN EMERGENCY_____PHONE_____

* I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

PATIENT/GUARDIAN SIGNATURE_____**DATE**_____

FOR DR. ONLY: PREMED Y N ALLERGIES Y N MEDICATIONS Y N

DR. INITIAL_____

MEDICAL HISTORY

FINANCIAL POLICY

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you the best possible care. To achieve these goals , we need your assistance and understanding of our payment policy.

Insurance

While the filing of insurance is a **courtesy** that we extend to our patients, **ALL charges are your responsibility regardless of your insurance coverage.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize that:

1. Your insurance is a contract between you, your employer, and the insurance company. **We are not involved in that contract.**

2. Most insurance payments are based on an arbitrary average of the fees for a particular region and may not reflect the accurate cost of dentistry in this area. Therefore dental services are covered up to the maximum allowance determined by each insurance carrier.
   This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. **Not all services are a covered benefit in all contracts.** Some insurance companies arbitrarily select certain services they will not cover.

Payment Due at Time of Service

Our policy is: **"Payment Due at Time of Service"**. No balances will be billed. Your **estimated** co-payment for treatment, which is the amount not covered by insurance, is due at the time treatment is provided. Your **estimated** co-payment may be adjusted after the time of treatment depending on the final reconciliation of insurance payments.

If you do not have insurance, we expect **full payment** for service at each office visit.

We accept these forms of payment:

Cash - Check - Master Card - Visa - Discover - American Express

**Payment plans are available upon approval through Care Credit.

Interest

Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% per month (18% annually).

Appointment Policy

I understand the cancellation policy which states “Reserved times cancelled within 48 hours are subject to a $50.00 cancellation fee”. An appointment cancelled within 48 hours limits our ability to fill the time with a patient in need. We appreciate your understanding and working with us to avoid this scenario.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don’t hesitate to ask us. We are here to help you.

I HAVE READ AND AGREE TO THE ABOVE TERMS.

_____ _____

Print name of patient or responsible party **Date**

_____ _____

Signature of patient or responsible party **Date**

Behner Family Dentistry
Julian W. Behner, D.M.D., P.A.
934 E. Altamonte Dr.
Altamonte Springs, FL 32701
407-831-5455

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed.

Federal and state laws require us to maintain the privacy of your health information. This notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the change. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations.
For example:

Treatment - We may use your health information for treatment or disclose it to a dentist, specialist, physician, or other health care provider providing treatment to you.

Payment - We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations - We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To Your Family and Friends - We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your healthcare. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location, and general condition. In the event of your incapacity or an emergency we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Appointment Reminders - We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

If you have any questions, please contact us.

Signed_____Date_____