Welcome.

We're glad you're here.

We know that going to the dentist may not be at the top of your "to do" list. But whether it's been six months or six years since your last visit, we're just glad you're here.

We promise to listen to your hopes and fears, jitters and concerns. To provide care without pressure, and advice without obligation. To deliver equal doses of care and honesty, because we're confident you'll trust us with your mouth when you know we have your best interests at heart.

And we'll stop at nothing to deliver an experience that is above and beyond what you thought dental care could be.

PRIME DENTISTRY

8640 E. County Road 466
The Villages, FL 32162
(352) 674-9077
www.MyPrimeDentistry.com

OFFICE USE ONLY: Acct. # _____

Health Information

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may effect your treatment. All information is confidential.

Patient's Name: _____Date of Birth: _____Last Physical Date: _____

Physician's Name & Phone #: _____Reason for today's visit? _____

Work Related Injury? (circle) **Yes** **No** Have you been under the care of a physician? (circle) **Yes** **No**

Have you ever been hospitalized? (circle) **Yes** **No**

Height: _____Weight: _____

Date of last dental visit:_____Date of last dental x-rays:_____Date of last cleaning:_____

Have you ever been treated for periodontal (gum) disease? (circle) **Yes** **No**

Ever had Novocaine or other local anesthetic? (circle) **Yes** **No**

Are you interested in tooth whitening? (circle) **Yes** **No**

If wearing dentures, age of dentures: _____Are you interested in new dentures? (circle) **Yes** **No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes** **No**

Are you taking or have taken Oral Bisphosphonates?(e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, (e.g., ZOMETA, AREDIA) (circle) **Yes** **No** Taken for how long? _____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes** **No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes** **No**

List any medications you are allergic to:

1. _____ 2. _____ 3. _____ 4. _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1. _____ 2. _____ 3. _____ 4. _____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Teeth Grinding/Clenching			Pace Maker/Heart Surgery			Asprin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain in your jaw (TMJ)			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type:)		
Any type of Transplant			Heart Problem ( )			Excessive Bleeding			Any Artificial Hip, Knee or other Joint		
Drug Addiction			Dialysis			Stroke			Other Disease or Illness:		
Hepatitis (Type:)			Chemotherapy			Lung Disease					
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)					

Women patients only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I here by give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature_____Date_____Dr's. Signature/Medical History Review_____Date_____

6 MONTH UPDATE → Patient's Signature_____Date_____Dr's. Signature/Medical History Review_____Date_____

OFFICE USE ONLY: Acct. # _____

Patient Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss
First: _____Middle: _____ Last: _____Jr/Sr: _____
Street: _____ City: _____ State:_____ Zip:_____
Home Phone: _____Work Phone: _____
Cell Phone: _____
Email Address: _____ May we contact you by email? (circle) **Yes No**
Patient Social Security Number:_____ Patient Date of Birth: _____Sex: (circle) **M F**
Emergency Contact:_____ Phone: _____
Preferred Pharmacy_____
How did you hear about us?
☐Newspaper ☐Radio ☐TV ☐Internet ☐Referral ☐Other: _____

Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present your insurance card to our patient services representative to be photocopied			

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:
Name of Recipient: _____
Relationship to the Patient: _____

I give authorization to disclose the following information:
- ☐ All treatment information
- ☐ Information specifically related to these treatment dates

Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying **Prime Dentistry** in writing.

Signature of Patient (or Patient Representative) _____ Date: _____
Printed Name of Patient (or Patient Representative) _____

Financial Policies

At Prime Dentistry, we are committed to giving you exceptional service and providing treatment that addresses both your short-term and long-term needs. We make it easier for you to get the care you need, which includes a commitment to every-day low prices, flexible financing options, and no surprises. We also accept a variety of payment options and will work with all insurers. We're committed to keeping our prices low so that you can get the care you need. We know you have a choice, and we appreciate your decision to trust us with your dental care.

1. A Clear, Written Estimate on the Cost of Treatment

Your dentist will provide you with a comprehensive treatment plan after assessing your overall oral health. We'll provide a clear, detailed estimate on the cost of your treatment plan in writing so you know what to expect, including your estimated insurance benefits.

If you have any questions related to your insurance coverage, we encourage you to contact your insurance company.

2. Payment Policy

The following payment policies apply:

- Payment in full of the Patient Financial Responsibility amount, as specified in the Treatment Acceptance and Payment Arrangement Form, is due no later than when services are rendered. Acceptable forms of payment include cash, personal checks, Visa®, Master Card®, American Express®, Discover®, assigned insurance benefits and select third-party financing programs.

- For comprehensive treatment plans requiring multiple office visits, a minimum deposit of 60% of the Patient Financial Responsibility amount is required.

- You may, at your discretion, elect to pay in full, in advance for comprehensive treatment plans. Refunds will be processed in accordance with our refund policy.

3. Refund Policy

You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive; provided, however, crown and bridge patients are responsible for the full cost of their treatment plan once preparation of your teeth has begun.

Your refund request will be handled as follows:

- Original Form of Payment. Refunds will be processed to the original form of payment, except cash payments will be refunded by check.

- Seven Days of Inactivity – New Patients. If you are a new patient who has had no treatment performed, has no scheduled appointments and has a credit balance on your account, after seven days of inactivity you will automatically receive either (a) a notice that you are entitled to a refund if you paid by cash or check or (b) an automatic refund to your original form of payment if you paid by credit card or with third party financing.

- 60 Days of Inactivity. Credit balances existing on accounts after 60 days of inactivity will be automatically refunded to the original form of payment, except cash/check payments, which will be notified by letter.

* 180 Days of Inactivity (Partial Denture Patients Only). Credit balances existing on accounts after 180 days of inactivity will be automatically refunded to the original form of payment, except cash payments will be refunded by check.

- Timing of Refunds.
  - » Cash/Check: After receiving your refund request, we will confirm that your payment has cleared the bank (may take up to 15 business days). Once cleared, you will be issued a refund check within ten (10) business days.
  - » Credit Card/Third Party Financing: Refunds will be issued to the form of payment within three (3) business days after receipt of your refund request. If you paid by credit card, it may take up to seven (7) business days for the credit card company to post the payment to your account.

- How to request a Refund

  Contact your office and request a refund
  Mail a refund request to:

  Prime Dentistry
  Attn: Refund Processing
  8640 E. County Road 466
  The Villages, FL 32162

4. Dental Insurance

If you have dental insurance, your insurance claim will be processed as follows:

- **In Network:** If your dentist is a participating provider with your insurance, you will be billed pursuant to the terms of your dentist's agreement with your insurer.
- **Out of Network:** If your dentist is not a participating or in-network provider with your insurance plan, we will honor your carriers in network fee structure. If your insurance carrier will not accept your assignment of benefits to your dentist, you are responsible for the estimated insurance benefit.
- **Insurance Discounts:** Insurance companies often negotiate discounts for services provided to their plan members. Should you exceed your annual benefit limit, the insurer's discounted rate may apply to additional services as a benefit to you. Prime Dentistry practice will honor your insurer's policy.

5. Third-Party Financing Disclosure

Prime Dentistry accepts payment from non-affiliated, third-party finance companies (i.e., CareCredit issued by Synchrony). Our office pays these companies fees on a sliding scale for making financing available to patients like you and for the finance companies cost of servicing these loans. As the aggregate amount of care financed through these finance companies increases, the fees they charge Prime Dentistry decrease. This sliding scale pricing arrangement does not affect the amount you finance or the cost of your treatment.

Credit decisions are solely the responsibility of these third-party finance companies. You may elect to pay all or a portion of your treatment using one of these third-party financing products.

6. Patient Satisfaction Inquiries

We are committed to providing you with exceptional service and care. If you have concerns, please call us at etc. or e-mail at dentist@myprimedentistry.com.

Receipt of Treatment Plan & Financial Policies

1. Payment, Insurance, and Financial Arrangement Policies (must be signed by ALL new patients).

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature_____Date_____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

2. Notice of Privacy Practices (must be signed by ALL new patients).

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature_____Date_____
(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

3. Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance).

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature_____Date_____
(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

4. Consent to obtain patient medication history.

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature_____Date_____
(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

Responsible Party (If patient is under 18 or disabled)

Circle One: Dr/Mr/Mrs/Ms/Miss

First:_____Middle:_____Last:_____Jr/Sr:_____

Street: _____City:_____State: _____Zip: _____

Home Phone: (____) _____Work Phone:(____) _____Cell Phone:(____) _____

Patient SSN: _____-_____-_____Patient Date of Birth: _____/_____/_____Sex:(circle) M F

Signature:_____Date:_____

*Retain Original in Patient's Chart