Mark L. Voltarel, DMD, P.A.
751 Harley Strickland Blvd. Orange City, FL 32763
(386) 774-4777

Patient Information

Patient Name: _____ Date: _____
Last First M

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work) _____ Best time to call: _____

E-Mail Address _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints/Implants
☐ Asthma
☐ Blood Disease/Thinners
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Low Blood pressure
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- List of current medications: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Turn Page Over Please

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The 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 all dental services furnished are charged directly to the patient and that he or 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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

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

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

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AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professional or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare professional providers and healthcare entities (such as: referral to or consultation with, other healthcare professional, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voice mail or with a household family member.
  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.
  [ ] Please check here if you do not want us to leave a message on you mobile voice mail.

- To discuss your health or payment information (only the minimum necessary in out judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- To choose, please list by name the relationship the persons with whom we may share your healthcare or payment information
  _____
  _____

- You may request a copy of, or as a new patient, will be given a copy of our "Notice of Patient Privacy Practices" that provided a more complete description of health information uses and disclosures as required by the HIPAA standard.

- You may read or have had the right to the "Notice of Patient Privacy Practices" prior to signing this authorization.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient name: _____

_____ _____ _____
Signature Print name of person signing Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP _____

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: _____ Date: _____

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Fax: (386) 774-1996

OUR FINANCIAL & INSURANCE POLICY

We thank you for choosing us as your dental health care provider. As part of our service, we try to contain the ever-rising cost of dental care. In order to do this, we have implemented a new financial policy.

All our fees will be due at the time treatment is rendered.

For our patients with dental insurance, we request that you pay your **guesstimated** portion of the treatment fee at the time services are rendered. You will be responsible for paying any balance Immediately after your insurance carrier has paid on a claim.

It is **your responsibility** to know what your insurance coverage covers for example: frequency, age limitations and maximum. We highly suggest that you read your dental insurance coverage pamphlet. You are **responsible** for anything your insurance **does not cover**.

If your primary insurance company does not pay within 45 days of our submission date, you will be Responsible for the entire balance and you must contact your carrier directly to resolve your claim. A copy of the claim will be provided to you.

We accept cash, checks, debit cards, visa, MasterCard and Discover as forms of payments.

By arrangement with CareCredit , we are able to offer our patients with a 3, 6, and 12 month interest free payment plans depending upon the amount of treatment. Application forms are available at the front desk.

We are always available to answer your questions or to assist you with your dental health care.

Thank You,

Signature_____ Date_____

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BROKEN APPOINTMENT POLICY

Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. Our standard office policy regarding appointments is as follows:

After we send out the appointment reminder cards, we try to remind patients by telephone prior to the appointment, but please do not depend on this courtesy. If we are unable to reach you, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present. That time has been reserved especially for you. We reserve the right to charge for office visits canceled or broken with out 48 hours advanced notice. Exceptions to this policy can be determined only on an individual basis according to the circumstances.

The broken appointment charge will depend on the procedure and time reserved. These charges are allowed by your insurance company and considered as your responsibility.

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 healthcare.

Date:_____ Signature:_____