Boyette Dental

10825 Boyette Road Riverview, FL 33569 | (813) 741-0483

PERSONAL INFORMATION

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr. **Date:**_____/_____/_____

Last Name: _____ **First Name:** _____ **MI:** _____

Preferred Name (Nickname): _____ **Date of Birth:**_____/_____/_____

SSN: _____ - _____ - _____ **Marital Status:** ( ) Married ( ) Single ( ) Other **Gender:** ( ) Male ( ) Female

Home Address: _____ **Apt #:**_____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number (Preferred): _(____)_____-_____ ( ) Cell ( ) Home ( ) Work ( ) Other

Phone Number (Alternate): _(____)_____-_____ ( ) Cell ( ) Home ( ) Work ( ) Other

Employer: _____ **Occupation:** _____

May we call you at work? ( ) Yes ( ) No **Email Address:** _____

IN CASE OF EMERGENCY

Name: _____ **Phone:** _(____)_____-_____

Relationship: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

( ) Internet (Google, Bing, Yahoo, etc.)
( ) Dental Insurance Company
( ) Friend
Name:_____

( ) Facebook
( ) Saw Our Sign
( ) Other
Specify:_____

Reason for Today's Visit: ( ) Routine Check-Up/Get Established as a New Patient.
( ) It's been a while, but I'm not having any problems.
( ) I have a problem I'd like addressed.
Explain: _____

DENTAL HISTORY

Name of Previous Dentist: _____ **Phone:** _(____)____-____

City/State: _____ **Date of Last Dental Appointment:** _____

Date of Last Professional Cleaning: _____ **Date of Last Dental X-Rays:** _____

Do you have any crowns (caps)?	( ) Yes	( ) No
Does food catch between your teeth?	( ) Yes	( ) No
Are your teeth sensitive to the following?		
Heat	( ) Yes	( ) No
Cold	( ) Yes	( ) No
Sweets	( ) Yes	( ) No
Biting/Chewing/Pressure	( ) Yes	( ) No

GUMS

Do you experience the following?

Bleeding gums when brushing	( ) Yes	( ) No
Swollen gums	( ) Yes	( ) No
Unpleasant taste/odor in mouth	( ) Yes	( ) No
Avoid part(s) of mouth while brushing	( ) Yes	( ) No
Bad breath	( ) Yes	( ) No

Have you ever been treated for (or told you have) periodontal disease? ( ) Yes ( ) No **If treated, when?**_____

Do you floss regularly? ( ) Yes ( ) No **If yes, how often?** _____

TMJ/TMD

Do you experience the following?

Pain, popping or locking in jaw joint	( ) Yes	( ) No
Pain when opening wide or yawning	( ) Yes	( ) No
Clenching or grinding teeth	( ) Yes	( ) No
Frequent headaches, migraines	( ) Yes	( ) No
Frequent neck/shoulder aches	( ) Yes	( ) No
Shifting/loose teeth or changes in bite	( ) Yes	( ) No

COSMETIC

Do you like your smile?	( ) Yes	( ) No	
Would you like your teeth whiter?	( ) Yes	( ) No	
Have you had orthodontics (braces)?	( ) Yes	( ) No	When was it completed?_____
Is there any old dental work you don't like?	( ) Yes	( ) No	Specify:_____
Is there anything you would like to change?	( ) Yes	( ) No	Specify: _____

REPLACEMENT TEETH

Do you have any of the following?

Missing teeth	( ) Yes	( ) No
Bridges (fixed) to replace teeth	( ) Yes	( ) No
Partials (removable) to replace teeth	( ) Yes	( ) No
Dentures	( ) Yes	( ) No
Dental Implants to replace teeth	( ) Yes	( ) No
Dental Implants to support dentures	( ) Yes	( ) No

COMFORT

Have you ever had a bad experience in a dental office that caused you anxiety, or does a particular noise or action make you nervous? ( ) Yes ( ) No

Specify: _____

Have you had nitrous oxide (laughing gas)? ( ) Yes ( ) No

Have you had IV Sedation (conscious sleep)? ( ) Yes ( ) No

Have you had Oral Sedation (sedative)? ( ) Yes ( ) No

Are you interested in trying sedation? ( ) Yes ( ) No

PHYSICIAN'S INFORMATION

Office Name: _____ **Phone:** _(_____)_____-_____

Physician's Name: _____ **Last Visit:** _____/_____/_____

GENERAL MEDICAL and HEALTH

Are you currently under a physician's care? ( ) Yes ( ) No

Specify: _____

Are you taking any medications? ( ) Yes ( ) No

Specify (include OTC drugs, vitamins, birth control, etc): _____

_____

Do you have any health problems? ( ) Yes ( ) No

Specify: _____

Have you ever had surgery? ( ) Yes ( ) No

Specify: _____

Are you allergic to any medications? ( ) Yes ( ) No

Medication: _____ Reaction: _____

Have you ever had a reaction to local anesthetic? ( ) Yes ( ) No

Specify: _____

Do you require premedication with antibiotics before appointments? ( ) Yes ( ) No

Specify: _____

GENERAL MEDICAL and HEALTH (cont'd)

To the best of your knowledge, do you have (or have you ever been afflicted) with any of the following?

Rheumatic Fever/ Heart Murmur	( ) Yes	( ) No
Mitral Valve Problems	( ) Yes	( ) No
Artificial joints or valves	( ) Yes	( ) No
Seizures/Epilepsy/Stroke	( ) Yes	( ) No
Heart Ailment	( ) Yes	( ) No
High Blood Pressure	( ) Yes	( ) No
High Cholesterol	( ) Yes	( ) No
Respiratory Disease	( ) Yes	( ) No
Asthma/Hay Fever	( ) Yes	( ) No
Diabetes	( ) Yes	( ) No
Thyroid Disease	( ) Yes	( ) No
Liver/Kidney Problems	( ) Yes	( ) No
Prolonged Bleeding	( ) Yes	( ) No
Healing Complications	( ) Yes	( ) No
Take Blood Thinners or Aspirin	( ) Yes	( ) No
Hepatitis/HIV	( ) Yes	( ) No
Gastrointestinal Problems	( ) Yes	( ) No
Drug/Alcohol Abuse	( ) Yes	( ) No
Do you smoke/ chew tobacco?	( ) Yes	( ) No
Are you taking any diet drugs?	( ) Yes	( ) No
Are you pregnant?	( ) Yes	( ) No

PATIENT TREATMENT CONSENT

I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to present to me all of my options so that I may make an informed decision as to my course of treatment. Once treatment is agreed upon, I authorize the Dentist(s) to perform needed dental treatment and administer or prescribe any necessary medications.

I authorize my Dentist(s) to release treatment records, x-rays, or any other information deemed pertinent to my insurance carrier as necessary and/or requested to process my claims. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All payments are due at the time of service.

_____ _____

Patient/Guardian Signature **Date**

_____

Dentist Signature

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HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by:

_____ _____

Printed Name of Patient or Representative | Signature of Patient or Representative

_____ _____

Relationship to Patient (if other than patient) | Date

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Social Media Informed Consent

Boyette Dental is pleased to participate in social media outlets such as Facebook, our website page, etc. Through these venues, we share staff pictures, office updates, new contests and other fun and helpful information updates that may benefit our patients. With the expressed permission of our patients, we are pleased to share posts congratulating patients on completing their treatment, announcing contest winners, and posting fun selfies and photos with our patients.

☐ I hereby grant Boyette Dental permission to take photographs of me, and to publish those photographs for any lawful purpose including, but not limited to, case presentations, promotional purposes and on their website and/or social media accounts.

☐ I do not consent to my photographs being published, posted, or shared on social media.

_____

Name of Patient

_____ _____

Signature of Patient (or Responsible Party) **Date**

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FINANCIAL AGREEMENT

Payment

-Payment is due at the time services are rendered, unless previous arrangements have been made with our Financial Coordinator.

-Returned checks will result in a $35 fee, along with the original amount due. We reserve the right to refuse future checks.

-In the event that your account is not paid as agreed, legal action may be taken and a collection fee of 33% of the unpaid balance will be added, as well as reasonable attorney's fees and/or court costs.

Insurance

-We are happy to work with your insurance to make sure you get maximum coverage for your dental treatment.

-As a courtesy to you, we will process insurance claims for you. **Please remember, however, that as dental providers, our relationship is with YOU, not your insurance company.** We have no control over the benefits of your plan and it is ultimately your responsibility to be aware of what your contract benefits are

Appointments

-Appointments must be confirmed at least 24 hours in advance to remain on the schedule. Unconfirmed appointments may be removed from the schedule.

- Because instruments, chair time and personnel are reserved exclusively for your appointment, we reserve the right to charge a broken appointment fee for appointments missed or cancelled without a 24 hour notice. Patients with a history of multiple missed/cancelled appointments may be asked to pre-pay for their appointment prior to scheduling.

-Patients who arrive late to their appointment may need to be rescheduled due to time constraints.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. We are here to help you.

I have read and understand the above financial policy and agree to meet all financial obligations.

Responsible Party Name	Responsible Party Signature	Date

Patient Name (Additional Family Member)	Patient Name (Additional Family Member)

Patient Name (Additional Family Member)	Patient Name (Additional Family Member)