RIVERBEND FAMILY DENTISTRY
10088 W INDIANTOWN RD
JUPITER, FL 33478

Phone: (561) 701-9700

riverbend FAMILY DENTISTRY

info@riverbendfamilydentistry.com

PATIENT INFORMATION

Patient Information: _____ Sex: M ☐ F ☐
Last Name First Name MI (preferred name)

Marital Status: _____ Birth Date: _____ SSN _____
mm/dd/yyyy

Preferred Music: _____ Student: Y N Name of School _____

Address: _____
Street City State Zip

Phone Numbers: ( ) _____ ( ) _____ ( ) _____
Home Work Cell

Email: _____

Preferred Contact Method: Cell Phone ☐ Email ☐ Text ☐
please select one

Emergency Contact Person: _____
Name Phone

Whom may we thank for referring you to our practice? _____ How did you hear about us? _____

INSURANCE INFORMATION

Insurance Subscriber: _____ Birth Date: _____
mm/dd/yyyy

Is subscriber a Patient? Yes ☐ No ☐

Subscriber's SSN _____ Subscriber's ID# _____

Subscriber's Address: _____ _____
(if different) Street Town State Zip

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other _____

Employer's Name: _____

Employer's Address: _____
Street Town State Zip

Insurance Plan Name: _____ Group # _____

Insurance Address: _____
Street Town State Zip

Insurance Phone: ( ) _____

Is Patient covered by additional dental insurance? Yes ☐ No ☐ If Yes:

_____
2nd Insurance Plan Name Group#

_____
Ins. Phone Ins. Address

CONSENT FOR TREATMENT, INSURANCE PAYMENT AUTHORIZATION AND FINANCIAL POLICY DISCLOSURE

My signature below shall serve as my informed consent to perform all recommended treatment. It shall also serve as authorization to assign any dental benefits paid by any third-party or insurer to my provider. If I have insurance I agree to make a payment of my estimated co-payment at the time services are rendered. I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, and coordination of benefit rules. After 60 days from the date of treatment any unpaid portion of my bill for services rendered shall be my sole and exclusive responsibility. Patients understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all balances. This office will help prepare insurance forms and assist in making collection from insurance companies: however, payment is ultimately the patient's sole and exclusive responsibility should the insurer or third-party payer fail, refuse or otherwise neglect to make payment. All collections from third-parties or insurers will be credited to the patient's account. If I do not have insurance, all fees for services rendered are due on the date of service unless prior arrangements have been made in writing.

This office reserves the right to charge a fee for appointment missed or canceled with less than 24 hours advance notice. Inconsideration for the professional services rendered to me by the Doctor, I agree to pay the reasonable value of said services to the Doctor or his assignee at the time services are rendered or within 15 days of billing if credit is extended. 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 agree to pay all costs of collection services incurred to collect any unpaid fees.

Signature _____ Date _____

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FAMILY DENTISTRY
QUALITY DENTISTRY IN A COMFORTABLE, HONEST AND FRIENDLY ENVIRONMENT

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician: ☐ Yes ☐ No

Please explain: _____

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins, or implants placed? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

Please list each one: _____

Have you ever had any surgical procedure? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken medications for bone density (ie Bisphosphonates, Fosamax, Boniva, Actonel etc.)? ☐ Yes ☐ No

Please list each one, including dosage and how long you took each med: _____

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Yes	No	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles

Yes	No	Conditions
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Other: _____

Yes	No	If Female, Please Answer
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If so, # of Weeks _____
☐	☐	Are you nursing?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

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FAMILY DENTISTRY

DENTAL HISTORY

How may we help you today? _____

Estimated date of your last dental visit: ____/____/____

Your current dental health is: _____

Is there anything that you would like changed about your smile? _____

Do you have severe anxiety about dental treatment? ☐ YES ☐ NO

Have you ever had an adverse reaction to dental treatment? ☐ YES ☐ NO

If YES, please explain: _____

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PRIVACY POLICY (HIPAA POLICY)

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 visiting our website at www.riverbendfamilydentistry.com

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, insurance billing, or healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

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 that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of the information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA Consent Form, therefore payment in full is required on the same day of services.

I, as the patient or parent/legal guardian, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment, insurance billing, and healthcare operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This legislation provides data privacy and security provisions for safe guarding your medical information.

You may also file a complaint if you feel your rights have been violated. You may contact our Privacy Officer, Shannon Lackner, 10088 W Indiantown Rd., Jupiter, FL 33478, 561-701-9700, shannon@riverbendfamilydentistry.com or US Department of Health and Human Services office for Civil Rights, 200 Independence Ave S.W., Washington, D.C. 20201, 877.696.6775 or www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate for filing a complaint.

I have been informed of this policy and have been offered a written copy.

Patient's Name: _____

Signature: _____ Date: _____

Effective date: September 23, 2013
Revised date: October 7, 2020