FAMILY, IMPLANT & COSMETIC DENTISTRY
Fadi Raffoul, D.M.D.

Patient Registration Form

Today's Date: _____

Patient Information (Please Print)

First Name: _____Middle Name _____ Last name: _____
Preferred Name: _____
Street: _____ City _____ State _____Zip _____
Gender: ☐M ☐ F ☐ unspecified Date of Birth: _____ Primary Language: _____
Home Phone: _____ Cell Phone _____
Occupation: _____ Email: _____@_____
How did you hear about us? _____

Responsible Party (If Different than above)

Name of person responsible for account: _____
Relationship to Patient: _____ Date of Birth: _____
Address _____ City _____ State _____Zip _____
Preferred Phone# _____ Email: _____@_____
Signature of responsible Party: _____

Insurance Information (Please Print)

Is Subscriber the same as patient? ☐Yes ☐ No

Subscriber information:

First Name: _____Middle Name _____ Last name: _____
Employer Name: _____ Insurance Company: _____
Insurance Phone #: _____ Subscriber ID Policy #: _____
Group Plan Name: _____Group #: _____
Subscriber SS#: _____ Subscriber Date of Birth: _____
Patient relationship to Subscriber: _____

Preferred Pharmacy (Please Print)

Name: _____ Phone Number: _____
Street: _____ City _____ State _____Zip _____

Health Information/ Medical History (Please Print)

Are you under the care of primary Physician? ☐Yes ☐No Date of Last Physical: _____
Physician's Name: _____ Physician's Phone #:_____
Have you in the past 2 years, or are you currently taken any steroids/Cortisone therapy? _____
Have you in the past, or are you currently taken any medications for osteoporosis/Osteopenia or Bone disease? _____
Have you been hospitalized, or have you ever had any surgery? _____

_____

Please list all allergies and possible allergies:

☐ None _____

Please list all medication you are taking including non-prescription drugs and herbals/Vitamins:

☐ None _____

_____

_____

Medical History (Please Print)

Please mark (x) to indicate if you have or have had any of the following:

☐ **None**

Cancer
Type _____
☐ Chemotherapy
☐ Radiation Therapy

Cardiovascular
☐ Angina (chest pain)
☐ Artificial Heart Valve
☐ Heart Conditions
☐ Heart Surgery
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Fever
☐ Stroke

Endocrinology
☐ Diabetes
☐ Hepatitis A/B/C
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Disease

Gastrointestinal
☐ Ulcers
☐ Stomach Disease

Hematologic/Lymphatic
☐ Anemia
☐ Blood Disorders
☐ Bruise Easily
☐ Excessive Bleeding

Musculoskeletal
☐ Arthritis
☐ Artificial Joints
☐ Jaw Joint Pain

Neurological
☐ Anxiety
☐ Depression
☐ Dizziness/Fainting
☐ Drug/Alcohol Addition
☐ Seizures
☐ Psychiatric Illness

Women
☐ Currently Pregnant
☐ Nursing

Respiratory
☐ Asthma
☐ Emphysema
☐ Respiratory Problems
☐ Sinus Problems
☐ Sleep Apnea
☐ Tuberculosis

Viral Infections
☐ AIDS/ HIV Positive
☐ HPV

Other
☐ Dementia

Any other medical condition not listed:
_____
_____

Additional Comments (Doctor only) _____

_____

_____

Dentall History (Please Print)

Reason For today's Visit: ☐ Check up ☐ Broken Tooth ☐ Cosmetic ☐ Tooth Pain ☐ Implants ☐ Dentures ☐ Wisdom Teeth

Other: _____

When was your last Dental Visit? _____ /_____ Last X-rays: _____ /_____ Where?:_____

On a scale from 0-10 (ten being the highest)

1. How important is your Dental health to you?	1	2	3	4	5	6	7	8	9	10
2. Where would you rank your current dental health?	1	2	3	4	5	6	7	8	9	10
3. Are you happy with appearance of your smile?	1	2	3	4	5	6	7	8	9	10
4. Do you have fear or anxiety about dental work?	1	2	3	4	5	6	7	8	9	10

Do you use Tobacco? ☐ Yes ☐ No how frequent? _____ How Long? _____

Do you use Alcohol? ☐ Yes ☐ No how frequent? _____ How Long? _____

Do you have any dental complaints, pain, or concerns? ..... ☐ Yes ☐ No

Does your gums bleed when brushing/Flossing? ..... ☐ Yes ☐ No

Is any of your teeth sensitive to sweets, cold and hot? ..... ☐ es ☐ No

Is any of your teeth sensitive to chewing and biting? ..... ☐ Yes ☐ No

Do you have trouble Chewing food you want to eat? ..... ☐ Yes ☐ No

Do you clench or grind your teeth at night or day? ..... ☐ Yes ☐ No

Do you want to change your smile? ..... ☐ Yes ☐ No

Are you nervous about dental injections? ..... ☐ Yes ☐ No

Have you ever had a reaction to Novocaine, epinephrine, or local anesthetic? ..... ☐ Yes ☐ No

Do you wear dentures or partial dentures? If so, how old are they? _____ ..... ☐ Yes ☐ No

Consent: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated.

_____

Signature of patient/legal Guardian **Print Name** **Date** **Doctor's Signature**

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Consent for Use and Disclosure of Health Information

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment;
- Obtaining payment from third party payers (e.g., my insurance company);
- The day-to-day healthcare operations of your practice.

I have been informed of, and given the right to review and secure, a copy of your *Notice of Privacy Practice*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

HIPAA Patient Questionnaire:

1. Please list the family members or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

_____ _____
Name Relationship

_____ _____
Name Relationship

2. Please list any person whom we may inform about your medical condition ONLY IN AN EMERGENCY

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

3. Can confidential messages (ie., appointment reminders) be left on your telephone answering machine or voicemail? Yes / No

_____
Printed Patient Name Name of Parent or Legal Guardian Date

_____
Patient/guardian Signature

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FINANCIAL POLICY AGREEMENT

Concerning Your Dental Benefits:

Dental insurance is a contract between you and the insurance company. Despite our efforts, there is no guarantee of benefits or reimbursement. As a courtesy, we will bill your insurance company on your behalf. If your insurance company has not made payment within 30 days, the outstanding balance becomes your responsibility.

Insurance co-payment and/or a deductible payment is the patient's responsibility. We verify insurance benefits as a courtesy to you. This is not a guarantee of payment from your insurance company. After your claim is processed, it is possible your balance will be different than our estimate.

If we are in-network with your insurance and your insurance does not cover the estimated portion, the patient is ultimately responsible for the full contracted fee. If we are out of network, the patient will be responsible for the full office fee minus any courtesy discounts offered.

Concerning Your Appointments:

We try to confirm appointments with a telephone call in advance as a reminder. Please return these calls to hold your appointment day and time. If an appointment is cancelled with less than 24 hours' notice, a broken appointment fee of $50 will be charged to you.

Other Billing Information
If you receive a bill in error, call our office to clarify your obligation. Returned checks or "insufficient funds" will be charged $35 per check.

Discounts:
We reserve the right to offer discounts for full treatment plan acceptance. If you decide to stop treatment before completion, you will be charged the full office fee for all services completed by the last appointment date. All discounts will be null.

Guaranty of Payment:
By signing below, I accept personal responsibility for the payment in full of my account.

_____ _____

Date **Signature**

Family, Implant & Cosmetic Dentistry
787 West Lumsden Road, Brandon, FL 33511 (813)684-7888

FAMILY, IMPLANT & COSMETIC DENTISTRY
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CONSENT FOR PHOTOGRAPHS, CONSULTATION & LOCAL ANESTHETIC

I consent to photographs being taken of me. I understand that they may be used for education, documentation and illustration of my treatment.

_____ Yes _____ No, I refuse (initials)

I consent to having patients with similar treatment needs call me for consultation, to learn more about what they might expect with treatment.

_____ Yes _____ No, I refuse (initials)

I consent to use of my photographs and/or testimonials for marketing, social media, and/or web site.

_____ Yes _____ No, I refuse (initials)

We would be happy to make you before and after pictures. Please let us know!

I consent to the use of local anesthetic as necessary. Without anesthetic, I may experience pain and success of treatment may be compromised. I recognize the risks of anesthetic include, but are not limited to: palpitations or racing heart; chest pain; dizziness or fainting; anxiety reaction; allergic reaction or death; trismus (jaw stiffness or difficulty opening); pain; swelling; lip or cheek biting; infection; bleeding or bruising; injury to nerves to the eyelid, lip or tongue, causing numbness or altered sensation, which may be permanent.

_____ Yes _____ No, I refuse (initials)

_____ _____
Patient, Parent or Guardian Date

_____ _____
Doctor Witness

Please contact us at (813)684-7888 if you have any questions. A doctor can be reached after hours.
787 W. Lumsden Rd, Brandon, FL 33511