SOSA
DENTAL & MEDICAL

Welcome To Our Office

Thank You for choosing our office for your families dental needs. We would like to make you aware of our office policies. Please feel free to ask our staff any questions you may have. Furthermore, please let us know if there is anything we can do to help make your visit more pleasurable.

1. **Payment is due when the service has been rendered.** This office does not provide private financing. However, we do offer Care Credit as a form of payment. Please ask for an application if interested or go to carecredit.com and apply.
2. If you have dental insurance we will be happy to file on your behalf. **However, we are not contracted with any insurance companies and we do not agree to their fees.** We are a PPO out of network provider and will work with your insurance to limit or eliminate any extra cost that could occur when working with an out of network provider. **You are expected to pay your percentage at the time of your visit.** Also, we can only provide you an approximate estimate of what your insurance plan is expected to pay to an out of network PPO provider. **If the full estimate is not paid by your insurance company, the remaining portion becomes your responsibility.** Some insurance companies will mail their portion of the dental bill to you the subscriber. We are still willing to work with you and your insurance if this is the case however, we will ask you for the full amount due at the time of service. If you have secondary insurance please let us know so that we can properly file a claim with your secondary insurance on your behalf.
3. We require you to sign a consent form for all services performed other than the routine basic dental care. (I.e. Root canal, Extractions, Implants, Final try in of partials and dentures, Bone grafting and periodontal treatment.
4. We are a high quality, low volume office which means we do not overbook so that we may provide you with the time for quality treatment. We call one to two days prior to your scheduled appointment to confirm this is a convenient time to accommodate your schedule. Your time is valuable and so is ours. **We require 24 hours' notice to change an appointment. There will be a $50.00 charge for any cancellations that were confirmed within this 24 hour period.**
5. Our office bills on a monthly basis. We require that all balances be paid before next appointment. **All balances over 90 days will be assessed finance charges in the amount of 1.5% of the balance. All balances over 120 days will be sent to our collection agency and any fees associated with your account will be applied and become your responsibility.**

Initials_____

I have read and understand the above information. I agree to the above office policies. I have had the opportunity to ask any and all questions regarding the office policies referenced above. All questions have been answered to my satisfaction.

Patient signature_____ Date_____

DENTAL & MEDICAL

321-633-SOSA (7672) 321-631-5555

780 E. Merritt Island Causeway Suite 6C
Merritt Island, FL 32952

Welcome To Our Office!

We appreciate the confidence you have placed with us to provide dental services. To assist us in serving you, please complete the following informational forms as they are important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please do not hesitate to ask.

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: _____

SSN: _____ Driver's License Number: _____

Home Address: _____

City: _____ State: _____ Zip Code_____

Billing Address if Different: _____

Phone: (H)_____ (C)_____ Email: _____

Employer/Occupation: _____ Work Phone: _____

Spouse's Name: _____ Phone Number: _____

Emergency Contact and Phone: _____

Name of Medical Doctor: _____

Phone Number: _____ Date of Last Visit to Medical Doctor: _____

Name of Previous Dentist: _____

Phone Number: _____ Date of Last Visit to Dentist: _____

One last question... Who do we thank for your referral: _____?

Insurance Information

Primary Insurance:

Insured's Name: _____

Insurance Company: _____

Address: _____

_____

Phone: _____

Member ID: _____

Group Number: _____

Employer: _____

SSN: _____

Secondary Insurance:

Insured's Name: _____

Insurance Company: _____

Address: _____

_____

Phone: _____

Member ID: _____

Group Number: _____

Employer: _____

SSN: _____

Insurance Agreement:

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy including benefits, limitations, and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at the time of service and is estimated according to my expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand that my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

_____ _____

(Signature of responsible Party) (Date)

PATIENT HIPPA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test result, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extent that the organization has already taken action in reliance thereon.

Signed this _____ day of _____ 20_____.

Patient Name (printed): _____

Signature: _____

Relationship to Patient: _____

Medical Health History

(Do you have, or have you had, any of the following.)

CONDITION	YES	NO
Heart Problems	___	___
Chest Pain	___	___
Shortness of Breath	___	___
High Blood Pressure	___	___
Low Blood Pressure	___	___
Heart Murmur	___	___
Heart Valve Problem	___	___
Artificial Heart valve	___	___
Taking Heart Medication	___	___
Rheumatic Fever	___	___
Pacemaker	___	___
Blood Problems	___	___
Easy Bruising	___	___
Abnormal Bleeding	___	___
Blood Disease	___	___
Anemia	___	___
Blood Transfusion	___	___
Allergy Problems	___	___
Hay Fever	___	___
Sinus Problems	___	___
Asthma	___	___
Intestinal Problems	___	___
Ulcers	___	___
Weight Gain/Loss	___	___

CONDITION	YES	NO
Special Diet	___	___
Constipation/Diarrhea	___	___
Kidney/Bladder Problems	___	___
Fainting Spells/Seizures/Epilepsy	___	___
Stroke(s)	___	___
Frequent or Severe Headaches	___	___
Thyroid Problems	___	___
Persistent Cough/Swollen Glands	___	___
Pre-Medication Required by Doctor	___	___
Cancer/Tumor	___	___
Diabetes	___	___
Urinate More Than 6x Day	___	___
Frequent Thirst or Dry Mouth	___	___
Family History of Diabetes	___	___
Tuberculosis	___	___
Bone or Joint Problems	___	___
Arthritis	___	___
Back or Neck Pain	___	___
Joint Replacement	___	___
Hepatitis, Jaundice, or Liver Trouble	___	___
Herpes or Other STD	___	___
HIV Positive/AIDS	___	___
Glaucoma	___	___
Head Injury	___	___

CONDITION	YES	NO
History of Alcohol/Drug Abuse	___	___
Do You Wear Contact Lenses	___	___
Do You Drink Alcohol	___	___

During the past 12 months have you taken any of the following?

Antibiotics or Sulfa Drugs	___	___
Anticoagulants (e.g. Coumadin)	___	___
High Blood Pressure Medication	___	___
Tranquilizers	___	___
Insulin, Tolbutamide, or Similar	___	___
Aspirin	___	___
Digitalis (or Other Heart Medication	___	___
Nitroglycerin	___	___
Cortisone (or Other Steroids)	___	___
Natural Remedies/Supplements	___	___

Are you allergic, or have you reacted adversely to any of the following?

Local Anesthetics (Novocain)	___	___
Penicillin or Other Antibiotics	___	___
Sulfa Drugs	___	___
Barbiturates/Sedatives/or Sleep Aids	___	___
Aspirin/Acetaminophen/Ibuprofen	___	___
Codeine/Demerol/Other Narcotics	___	___
Metals	___	___
Latex or Rubber Dam	___	___

Other: _____

What medications are you are currently taking? Please list all prescription and OTC supplements:

_____

_____

_____

_____

_____

WOMEN ONLY

Are You Taking Contraceptives or Other Hormones? _____

Are You Pregnant? _____

If So, Expected Delivery Date: _____

Have You Reached Menopause? _____

If So, Do You Have Any Symptoms? _____

_____

I hereby certify my responses are true to the best of my knowledge.

_____

(Patient Signature & Date/ Legally Authorized Representative)

_____

(Printed Name and Relationship if Signed on Behalf of the Patient)

_____

(Doctor Signature and Date)