Dr. Christopher R. Stock

WELCOME TO PALMS DENTAL!!

PATIENT REGISTRATION

Please complete the following confidential information in full for optimum understanding of your dental wishes and desires. Everyone has individual needs, so we want to give you personal attention to assure you the most comfortable dental experience possible.

Patient Name____

Address____

City____________________State_______Zip____________

Date of Birth_____/_____/____ [ ] Male [ ]Female

Social Security #__________-_______-__________

[ ]Married [ ] Single [ ] Divorced [ ] Widow

Employer____

School ____

Responsible Party__________________________________

Relation to Patient_________________________________

Address____

City____________________State______Zip____________

Social Security # __________-_______-__________

Emergency Contact_______________________________

Relationship_______________________________________

Home Phone (_______)___________-____________

Work Phone (_______)___________-____________

Cell Phone (_______)___________-____________

I was referred by

[ ]Drove by [ ]Website [ ]Insurance Co [ ]Other

[ ]Friend Name_____________________________

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patients' dental records.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment **mutually agreed upon** by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents entails certain risk. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Signature ________________________ ____/____/____
Name ___________________ Relationship____________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES FOR PALMS DENTAL

I, (patient or guardian's name)______________________,
Acknowledge that I have received a Notice of Privacy Practices from Palms Dental.

I authorize Palms Dental to discuss my medical/dental history, treatment options and account with:
_________________________ relationship______________
_________________________ relationship______________
_________________________ relationship______________

I authorize Palms Dental to call, leave messages, text message and email me at:
Home Phone (_______)___________-____________
Work Phone (_______)___________-____________
Cell Phone (_______)___________-____________
Email ______________________________________

Signature ________________________ ____/____/____
Name ___________________ Relationship____________

To be Completed by Palms Dental Staff

Good Faith Effort to Obtain Acknowledgement of Receipt was ____
Describe reason why the individual would not sign this form
____
I attest that the above is correct.
Signature ________________________ ____/____/____
Name ___________________ Title ____________

WHAT IS DENTAL INSURANCE?

Dental Insurance is NOT like medical insurance! Dental Insurance is a form of benefit that offers patients a supplement to (1) help pay for a portion of their treatment and (2) offers their members a discounted rate over a non-insured individual. Each patient's employer purchases dental insurance for their company. For that reason every single dental plan is different. For example, 2 different people may have MetLife insurance; however their benefits may be completely different. At Palms Dental we agree to help our patients sort through their dental insurance coverage by submitting all appropriate claims with x-rays and Dr. Stock's explanation of what was competed at that appointment and why. However, the insurance contract is with the patient and the insurance company. It is the patient's responsibility to know some very important pieces of information about their contract so you do not encounter any surprises.

Waiting Periods – These are periods of time that must elapse before the insurance company pays a benefit. (These usually occur for new members for 1 year's time and cover major work like; crowns, bridges, dentures, partial dentures etc.)
Replacement Periods - these are the amounts of time that must lapse before the same tooth can receive a benefit. (Example: most crowns must be 5-10 year old before the insurance company will allow another benefit to be paid.)
Alternative Benefit – This is the downgraded benefit the insurance company pays for another alternative procedure instead of the actual procedure preformed. (This is the biggest area where patients get the most confused. Most insurance companies pay for the back teeth to have "silver/tin" colored fillings and crowns. They do not cover tooth colored or porcelain fillings and crowns. Some insurance companies also pay a lower benefit for bridges if there are multiple missing teeth.)
Missing Tooth Clause – This is what it says. If there was a tooth missing prior to insurance coverage they will not cover for any replacement work such as a bridge, partial denture or implant.
Dental Insurance Maximum – This is the maximum amount your insurance company will pay out in a 12 month period. This is for *all* dental work including specialist. The 12 month period may be a calendar year or it may be another 12 month corporate cycle.

There are other policy provisions which may be specific to your employer and will affect your dental benefits. Sometimes dental work is necessary to prevent further decay, pain, damage, or loss of a tooth when there is no dental insurance benefit. Dr. Stock will inform you of your complete dental treatment by presenting to you a Treatment Proposal, regardless of insurance. We do our best to present a good faith estimate on that proposal. However, with the various policy provisions it is impossible for us to provide you with a precise dollar amount. **YOUR INSURANCE COMPANY MAY NOT PAY THEIR ESTIMATED PORTIONS. YOU ARE RESPONSIBLE FOR ALL CHARGES NOT PAID BY YOUR INSURANCE PAST 60 DAYS.**

Signature ________________________ ____/____/____
Name ___________________ **Relationship**____________

ADVICE ON FEES AND SERVICES

It is the general policy of our office that all professional services rendered are charged to the patient and are ultimately the patient's responsibility. **PAYMENT IS EXPECTED ON THE DATE OF YOUR VISIT FOR SERVICES RENDERED.** For your convenience, we accept, cash, personal checks (Fl checks with a valid FL driver's license only), Visa and MasterCard. However, once services are rendered, any stop payments, insufficient funds, or charge backs will be in breach of this contract and will be prosecuted by the law.

Cancellation Policy

Dr. Stock schedules each portion of the day to be with a specific patient, and other procedures are often scheduled around your appointment. **WE NEED TO KNOW AT LEAST 2 WORKING DAYS (THIS DOES NOT INCLUDE FRIDAY, SATURDAY, OR SUNDAY CANCELLATIONS) IN ADVANCE, WHENEVER POSSIBLE, THAT A PATIENT CANNOT KEEP THEIR APPOINTMENT. IN THE EVENT THAT YOU FAIL TO KEEP YOUR APPOINTMENT WITH LESS THAN 2 WORKING DAYS PRIOR NOTICE OR WITHOUT NOTIFYING US AT ALL, WE RESERVE THE RIGHT TO CHARGE A $50 FEE FOR EACH 45 MINUTES SCHEDULED.**

Dental Insurance Financial Agreement

Insurance co-payments and the remaining deductibles are due prior to scheduled procedures, any portion of our fee which your insurer fails to pay becomes your responsibility and is payable in full. **SIXTY (60) DAYS AFTER THE PROCEDURE IS PERFORMED, ANY AMOUNT OF OUR FEE OUTSTANDING (REGARDLESS OF INSURANCE) WILL BE TURNED OVER TO COLLECTIONS INCLUDING ATTORNEY FEES AND LEGAL COSTS**. In rare instances, unforeseen, secondary conditions may become evident during the procedure and, in the best judgment of the dentist, will require immediate additional services. We will attempt to bill your insurance should this occur, but if they fail to pay, you will be held responsible.

The insurance policy belongs to you and we have no leverage to ensure payment from your carrier. Dental insurance policies: restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premiums paid by you or your employer for the insurance, not on our fees or recommended treatment. Please keep our office informed of any changes in your insurance, employment or personal information. **IT IS YOUR RESPONSIBILITY TO BECOME FAMILIAR WITH YOUR POLICY EXCLUSIONS, LIMITATIONS, ALTERNATIVE BENEFITS, DEDUCTIBLES, AND REQUIRED PAYMENTS.**

I hereby authorize Palms Dental, P.A. to release to my insurance company, information acquired during the course of my dental care and authorizes the benefits to be paid directly to Palms Dental, P.A. I understand that I am responsible for any unpaid balances.

Signature ________________________ ____/____/____
Name ___________________ **Relationship**____________

Dr. Christopher R. Stock

Patients Name_______________________________________ Birthdate _____/_____/_____ Age __________

Why are you now seeking dental treatment?____

1. Are you in good health now [ ]Yes [ ]No ; If yes explain___________________________
2. Are you under the care of a physician [ ]Yes [ ]No ; If yes explain___________________________
3. Have you ever been hospitalized or had serious illness? [ ]Yes [ ]No ; If yes explain___________________________
4. Do you have excessive bleeding or cuts take longer to heal? [ ]Yes [ ]No ; If yes explain___________________________
5. [Women] Are you pregnant? [ ]Yes [ ]No ; If yes due date___________________________
6. Do you use tobacco in any form? [ ]Yes [ ]No ; If yes how much__________________________
7. Do you use more than 2 alcoholic beverages per day [ ]Yes [ ]No ; If yes how much__________________________

GENERAL

Tire easily, weakness [ ]Yes [ ]No
Marked weight change [ ]Yes [ ]No
Night Sweats [ ]Yes [ ]No
Persistent Fever [ ]Yes [ ]No

SKIN

Eruptions (rash) hives [ ]Yes [ ]No
Change is skin color [ ]Yes [ ]No

EYES

Visual Change [ ]Yes [ ]No
Glaucoma [ ]Yes [ ]No

EARS

Loss of Hearing [ ]Yes [ ]No
Ringing in ears [ ]Yes [ ]No

NOSE

Frequent Nose Bleeds [ ]Yes [ ]No
Sinus Problems [ ]Yes [ ]No

Throat

Soreness/hoarseness [ ]Yes [ ]No

NERVOUS SYSTEM

Stroke [ ]Yes [ ]No
Headaches [ ]Yes [ ]No
Convulsions/epilepsy [ ]Yes [ ]No
Numbness/tingling [ ]Yes [ ]No
Dizziness/fainting [ ]Yes [ ]No
Psychiatric treatment [ ]Yes [ ]No

RESPIRATORY

Tuberculosis [ ]Yes [ ]No
Emphysema [ ]Yes [ ]No
Asthma/hay fever [ ]Yes [ ]No
Persistent cough [ ]Yes [ ]No
Sputum (phlegm) [ ]Yes [ ]No
Cough up bloody sputum [ ]Yes [ ]No
Difficulty breathing [ ]Yes [ ]No

Endocrine

Diabetes [ ]Yes [ ]No
Family history of diabetes [ ]Yes [ ]No
Thyroid condition/goiter [ ]Yes [ ]No

HEART/BLOOD VESSELS

Rheumatic Fever [ ]Yes [ ]No
Heart Murmur [ ]Yes [ ]No
Chest Pain/discomfort [ ]Yes [ ]No
Heart Attack/trouble [ ]Yes [ ]No
Shortness of Breath [ ]Yes [ ]No
High Blood Pressure [ ]Yes [ ]No
Congenital heart disease [ ]Yes [ ]No
Artificial heart value [ ]Yes [ ]No
Pacemaker [ ]Yes [ ]No
Heart surgery [ ]Yes [ ]No
Other ________________________

BONE/MUSCLE

Arthritis/rheumatism [ ]Yes [ ]No
Artificial joints [ ]Yes [ ]No

DIGESTIVE SYSTEM

Hepatitis [ ]Yes [ ]No
Jaundice [ ]Yes [ ]No
Ulcers [ ]Yes [ ]No
Change in appetite [ ]Yes [ ]No
Black, bloody, pale stools [ ]Yes [ ]No

URINARY

Kidney Disease [ ]Yes [ ]No
Increase in urination [ ]Yes [ ]No
Burning on urination [ ]Yes [ ]No
Urethral discharge [ ]Yes [ ]No
Bloody urine [ ]Yes [ ]No
Venereal disease [ ]Yes [ ]No

BLOOD

Bruise easy [ ]Yes [ ]No
Anemia [ ]Yes [ ]No
Blood transfusions [ ]Yes [ ]No

OTHER

Radiation therapy [ ]Yes [ ]No
Tumors or growths [ ]Yes [ ]No
Cancer [ ]Yes [ ]No
AIDS [ ]Yes [ ]No
HIV [ ]Yes [ ]No
Other ________________________

KNEE/JOINT/HIP OR OTHER ARTIFICIAL REPLACEMENTS

Pins [ ]Yes [ ]No Where:______________ Date Placed:_______________
Plates [ ]Yes [ ]No Where:______________ Date Placed:_______________
Screws [ ]Yes [ ]No Where:______________ Date Placed:_______________
Other________________________________ Where:______________ Date Placed:_______________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, I will inform the dentist at my next dental appointment.

Signature _________________________ ____/____/____ **Name** ____________________ **Relationship**_____________

Dr. Christopher R. Stock

ALLERGIES – have you ever had a reaction to

Local Anesthetics (ie Novocain)	[ ]Yes	[ ]No
Barbiturates/sedatives/sleeping pills	[ ]Yes	[ ]No
Penicillin/other antibiotic	[ ]Yes	[ ]No
Aspirin or codeine	[ ]Yes	[ ]No
Sulfa drugs	[ ]Yes	[ ]No

Other drug allergies ___________________________________

Physicians Name___________________________

Physician Phone___________________________

Cardiologist Name_________________________

Cardiologist Phone_________________________

If Pregnant:

OB/GYN Name____________________________

OB/GYN Phone____________________________

CURRENT MEDICATIONS – are you taking any of the following?

Antibiotics/sulfa drugs	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Blood thinners	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Blood Pressure Medications	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Thyroid Medications	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Cortisone/Steroids	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Antihistamines/allergy drugs	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Cold remedies	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Tranquilizers	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Insulin/diabetes drugs	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Recreational drugs	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Digitalis/Heart medications	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Nitroglycerin	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Aspirin	[ ]Yes	[ ]No	Name of drug ______________________	dosage_________
Other Medications			Name of drug ______________________	dosage_________
			Name of drug ______________________	dosage_________
			Name of drug ______________________	dosage_________
			Name of drug ______________________	dosage_________
			Name of drug ______________________	dosage_________
			Name of drug ______________________	dosage_________
			Name of drug ______________________	dosage_________
			Name of drug ______________________	dosage_________
			Name of drug ______________________	dosage_________

DENTAL TREATMENT

Date of last dental exam? ____________________________

Have you ever had any serious trouble with dental treatment [ ]Yes [ ]No ; If yes explain____________________________

Does dental treatment make you nervous? [ ]Yes [ ]No ; If yes explain____________________________

Have you ever been treated for periodontal disease? [ ]Yes [ ]No ; If yes explain____________________________

Mouth			Teeth		
Bleeding, sore gums	[ ]Yes	[ ]No	Loose teeth	[ ]Yes	[ ]No
Unpleasant taste/bad breath	[ ]Yes	[ ]No	Sensitive to hot	[ ]Yes	[ ]No
Burning tongue/lips	[ ]Yes	[ ]No	Sensitive to cold	[ ]Yes	[ ]No
Frequent blister, lip/mouth	[ ]Yes	[ ]No	Sensitive to sweets	[ ]Yes	[ ]No
Swelling/lumps in mouth	[ ]Yes	[ ]No	Sensitive to biting	[ ]Yes	[ ]No
Orthodontic treatment [braces]	[ ]Yes	[ ]No	Food Impaction	[ ]Yes	[ ]No
Biting cheeks/lips	[ ]Yes	[ ]No	Clenching/grinding	[ ]Yes	[ ]No
Clicking/popping jaw	[ ]Yes	[ ]No	Shifting of teeth	[ ]Yes	[ ]No
Difficulty opening or closing jaw	[ ]Yes	[ ]No	Change in bite	[ ]Yes	[ ]No
Do you Brush	[ ]Yes	[ ]No	Manual Toothbrush	[ ]Yes	[ ]No
Do you Floss	[ ]Yes	[ ]No	Electric Toothbrush	[ ]Yes	[ ]No
Use Fluoride Rinse	[ ]Yes	[ ]No	Tooth Brush is [ ] Soft, [ ] Medium, [ ] Hard		

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, I will inform the dentist at my next dental appointment.

Signature ________________________ ____/____/____ **Name** ___________________ **Relationship**____________