



BELTRAN DENTAL SURGERY

11424 N 56th Street
Temple Terrace, FL 33617
Office: 813-373-4573
Fax: 813-388-6825
www.beltrandentalsurgery.com

Patient Registration

Date: _____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____ Sex: Male Female

Birth Date: _____ Social Security #: _____ Employer: _____

Student Status: Full Time Part Time
Name of School: _____

How did you hear about us? _____

Referred By: _____ Previous Dentist: _____ Reason For Visit: _____

Emergency Contact: _____ Emergency Contact Phone: _____ Second Phone: _____

Responsible Party: Same as Above

Relationship to Patient: Self Spouse Child Other

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____ Sex: Male Female

Birth Date: _____ Soc Sec: _____ Employer: _____

Primary Insurance Information:

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ City, State, Zip: _____

Policy ID Number: _____ Group Number: _____ Effective Date of Coverage: _____ Cal/Fis Year

PPO/UCR Annual Maximum: \$ _____ Benefits Used to Date: \$ _____ Deductible: \$ _____ Met: Y/N Applies: Prev/Basic/Major

First name: _____ Last name: _____

BP _____

Age _____

Pulse _____

Area _____

Medical History

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with oral surgery. Thank You for taking the time to answer the following questions.

Are you under a physician's care now? Yes No
 If yes, who is your doctor? _____

Have you ever been hospitalized or had any operations? Yes No
 If yes, why were you hospitalized or operated? _____

Have you ever had a serious head or neck injury? Yes No
 If yes, when and why? _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No
 If yes, when? _____

Are you on a special diet? Yes No
 If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No
 If yes, please list the medications: _____

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? Yes NO

Aspirin Penicillin Codeine Eggs/Soy Metal Latex Local Anesthetics Sulfa-drugs Other: _____

Do you have, or have had, any of the following? Please circle ALL that apply

- | | | | |
|---------------------------|---------------------------|-----------------------|----------------------------|
| Heart Problems | Cortisone Medicine | Hepatitis B or C | Scarlet Fever |
| Lung Problems | Diabetes | Herpes | Shingles |
| Breathing Problems | Drug Addiction | Hemophilia | Sickle Cell Disease |
| Bleeding problems | Easily Winded | High Blood Pressure | Sinus Trouble |
| AIDS/HIV Positive | Emphysema | Hives or Rash | Spina Bifida |
| Alzheimer's Disease | Epilepsy or Seizures | Hypoglycemia | Stomach/Intestinal Disease |
| Anaphylaxis | Excessive Bleeding | Irregular Heartbeat | Stroke |
| Anemia | Excessive Thirst | Kidney Problems | Swelling of Limbs |
| Arthritis/Gout | Fainting Spells/Dizziness | Leukemia | Thyroid Disease |
| Artificial Heart Valve | Frequent Cough | Liver Disease | Tonsillitis |
| Artificial Joint | Frequent Diarrhea | Low Blood Pressure | Tuberculosis |
| Asthma | Frequent Headaches | Lung Disease | Tumors or Growths |
| Blood Disease | Genital Herpes | Mitral Valve Prolapse | Ulcers |
| Blood Transfusion | Glaucoma | Pain in Jaw Joints | Venereal Disease |
| Bruise Easily | Hay Fever | Parathyroid Disease | Yellow Jaundice |
| Cancer | Heart Attack/Failure | Psychiatric Care | |
| Chemotherapy | Heart Murmur | Radiation Treatments | |
| Chest Pains | Heart Pace Maker | Recent Weight Loss | |
| Cold Sores/Fever Blisters | Heart Trouble/Disease | Renal Dialysis | |
| Congenital Heart Disorder | Hemophilia | Rheumatic Fever | |
| Convulsions | Hepatitis A | Rheumatism | |

Have you ever had any serious illness not listed above? Yes No If yes, what illness: _____

Have you ever had sleep apnea or do you snore when you sleep? Yes No If yes, please explain: _____

Have you ever had head or neck radiation? Yes NO If yes, when and how many treatments: _____

Have you ever had bisphosphonate therapy (FOSAMAX, AREDIA, ZOMETA) or medications to strengthen your bones? Yes NO

Do you smoke? Yes No If yes how many packs per day? _____

Do you consume alcohol? Yes NO If yes, how many per day/week or month? _____

Have you ever used any Recreational Drugs? Yes NO If yes, which ones? _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____



FINANCIAL POLICY

Thank you for choosing Beltran Dental Surgery as your dental health care provider. We are committed to providing you with the most comprehensive dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment and this financial agreement is intended to facilitate our ability to provide excellent service to you.

Payment is due prior to the service provided. Our office accepts cash, Visa, and MasterCard and debit card with Visa/MasterCard logo. Financing is also available through Care Credit upon approval.

We must emphasize that **our service is to you, our patient, not your insurance company.** Deductibles, co-insurances and /or co-payments are expected at the time of service. All charges you incur are **your responsibility** regardless of your insurance coverage. As a *courtesy*, Beltran Dental Surgery will file on your behalf to your insurance company. Please understand that we will provide an insurance coverage estimate to you, however, this estimate is **NOT** a guarantee that your insurance will pay exactly as estimated. The Treatment Plan estimate is valid for 90 days from the proposed date. Your co-payment amount may possibly be adjusted upon the final insurance payment. Your insurance company ultimately determines how much the insurance pays and how much you pay. If you are issued a credit on your account after all payments have been received, It is the your responsibility to request a refund before 90 days or the refund will no longer be available as a credit to your account.

As a *courtesy* to you we will **HELP** you process insurance claims, but please remember, your dental insurance plan is a contract between you, your employer, and your dental insurance company. Our office is **NOT** a party to that contract. If payment from your insurance company is not received within 30 days, you will be expected to pay balance in full.

We ask that you inform us immediately with any changes in your insurance coverage. Failure to do so may result in the inability of our office to file your claim, and thus you will be responsible for payment in full regardless of your insurance situation.

A non-refundable \$200.00 deposit will be collected to schedule procedure appointments and payment will go towards treatment. Patients who do not cancel their appointment 48 business hours prior to the time of the appointment will lose their deposit. We make every effort to confirm your appointment unless we hear otherwise from you.

Balances older than 30 days will **BE PENALIZED \$35.00 EVERY 30 DAYS**. If your account becomes past due, we will take the necessary steps to collect this debt. In the case it becomes necessary for our office to enlist the services of a collection service or litigation, you will be responsible for any collection/court cost or attorney fees associated with associated with such collection.

I HAVE READ, UNDERSTAND, HAVE HAD ALL MY QUESTIONS ANSWERED ABOUT THE FINANACIAL AGREEMENT AND ACCEPT THE FINANCIAL POLICY OF BELTRAN DENTAL SURGERY.

Name of patient or responsible party:

Date:

Signature:

Patient Acknowledgement of Notice of Privacy Practices

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care options.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

- The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

My diagnosis, treatment, and medications may be discussed with?

Name and relationship:

Date:

Patient Signature:

Patient's Name Printed Out:



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AUTHORIZATION TO OBTAIN AND THE RELEASE OF INFORMATION & CONSENT TO RECEIVE, MAIL, OR TELEPHONE MESSAGES

I hereby authorize Beltran Dental Surgery to release any/all of my medical/dental information for the purpose of:

- Any request from my insurance company
- Any Dentist, Physician, or Specialist I am referred to (General Dentist, Endodontist, Periodontist, Oral Surgeon)

I understand that the information that may be released may include confidential medical/dental information that was provided by me. I hereby release Beltran Dental Surgery from all legal responsibility or liability that may arise from the action I have authorized above. I also give consent to receive mail or telephone messages from Beltran Dental Surgery.

PATIENT NAME:

Date:

SIGNATURE: