Everyone Loves a Gentle Dentist

Travis W. Bennett, DMD

Date _____

We are a health-centered dental practice, and we are concerned with your total well-being. Please fill out health questionnaire completely, even if some of the questions may not seem relevant to your dental

_____ / / M F S M D W _____

Name (Last) (First) (Middle) Date of Birth Sex Marital Status Social Security Number

_____

Mailing Address City St Home Phone Cell Phone Email

_____

Name of Employer Occupation (Student) Name of School

_____

Height Weight Spouse's Name Children's names and ages

_____

Dental Insurance Co Name of Insured Relationship to you Their Employer

_____

Name of Emergency Contact Phone Number

_____

General Health (please check): Excellent Good Fair Poor Physicians Name Phone Number

Are you pregnant? Yes No If yes, expected delivery date _____
Do you smoke? Yes No If yes, how much _____
Are you allergic to any medication? Yes No If yes, names of medications _____
Are you taking any medication now? Yes No If yes, names of medication and reason _____
Medication 1- _____ Taken for _____ Medication 2- _____ Taken for _____
Medication 3- _____ Taken for _____ Medication 4- _____ Taken for _____

Have you ever had (please check all that apply):

Heart Disease	Yes	No	Cancer_____	Yes	No
Rheumatic Fever	Yes	No	Mitral Valve Prolapse	Yes	No
Abnormal Blood Pressure	Yes	No	Ulcers_____	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No
Jaundice	Yes	No	Diabetes	Yes	No
Epilepsy	Yes	No	Asthma or Hay Fever	Yes	No
Anemia	Yes	No	Sinus Trouble	Yes	No
Congenital Heart Lesions	Yes	No	Hepatitis	Yes	No
Arthritis	Yes	No	X-ray Treatment for Cancer	Yes	No
Lymph Node Enlargement	Yes	No	Glaucoma	Yes	No
Dry Mouth	Yes	No	AIDS	Yes	No
Stroke	Yes	No	Prolonged Bleeding	Yes	No
Latex Allergy	Yes	No	Artificial Joints	Yes	No
Autism	Yes	No	Pacemaker	Yes	No

If you answered "yes" to any of the above, please explain: _____

_____

What are your hobbies or interests? _____
How did you hear of Dr. Bennett _____

FORMS OF PAYMENT AND BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following operations: Cash, Check, American Express, Discover, MasterCard, Visa or a Dental Fee Plan. Balances over 90 days may incur a finance charge of 18%APR.

INSURANCE

Our office accepts PPO and/or private insurance plans only.

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. If your carrier is up to date (in over 70% of the cases), the claims will be transmitted via computer modem, before the end of the treatment day.
As a courtesy, in addition to filing the claim, **we will only ask for you *estimated* copayment.** Treatment and financial estimates are subject to change if dental procedures are altered in any way. Please understand that due to the differences in insurance companies allowable fee schedules we are only able to estimate your percentage due on the day of your appointment.
When your insurance company pays, we will settle any differences between the actual payment and our estimate with you. The difference will be due upon receipt of our statement. Any overpayments by you will be reimbursed to you when dental treatment has been completed.

The range of benefits depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range.

Most plans base amount of benefit on a schedule of fees arbitrarily developed by the insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that they will pay 80% of the cost specific treatment, **it means 80% of the fee determined by the insurance company and not the actual fee charged by our office.**

The final obligation for dental treatment is between you and our office. The insurance company is responsible to you and not our office.

If unable to keep your reserved appointment, kindly give a 48 hour notice, otherwise a charge will be made for the time reserved.

I have read, understand and accept the terms of the financial policies outlined above for dental service and I understand that I am ultimately responsible for all the charges incurred as a result of treatment by Dr. Bennett. I have also read the information regarding the HIPPA privacy notice.

Acknowledgement of review of Notice of Privacy Practices:

I, (print)_____ have reviewed a copy of this office's Notice of Privacy Practices.

Signature _____ **Date** _____

Assignment of Benefits Form

Practice Name: Travis W. Bennett, DMD
Address: 102965 Overseas Highway
City, State, Zip: Key Largo, FL 33037
Phone: 305-451-2616

Date_____
Patient_____
ID#_____
Group#_____

I, _____, understand that services rendered to me by Travis W. Bennett, DMD are my financial responsibility and that the provider will bill my insurance company, _____ as a courtesy. I authorize my insurance company to pay my benefits directly to Travis W. Bennett, DMD and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company, _____.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Travis W. Bennett, DMD within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid additional cost and inconvenience, should the insurance company forward payment to me, I authorize Travis W. Bennett, DMD to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness_____

_____

Signature of Policyholder Patient or Guardian