Conte Dental
8899 Timberwilde Drive
Unit # 1
Bonita Springs, FL 34135
(239)947-6646

NAME: ____________________________________ DOB: ____________ MALE__ FEMALE__

SPOUSE NAME: ____________________________ YOUR SOCIAL SEC #_____________________

ADDRESS: ____________________________________ CITY/ST/ZIP: ______________________

SECONDARY ADDRESS: ____

LOCAL PH # __________________ WORK # ____________________ CELL#____________________

EMAIL ADDRESS:____

EMERGENCY CONTACT: __________________________________ PHONE: ____________________

PLACE OF EMPLOYMENT: ____

DENTAL INSURANCE: ________________________________ PHONE #________________________

POLICY HOLDER: ___________________________ DOB: ___________ S.S.#___________________

NAME OF PRIMARY PHYSICIAN: ___________________________ PHONE # __________________

DATE OF LAST DENTAL VISIT? _________________________

REASON FOR TODAY'S VISIT? __________________________

HAVE YOU HAD A FULL SERIES OF X-RAYS IN THE LAST YEAR? _________________________

PLEASE LIST ALL MEDICATIONS INCLUDING OVER THE COUNTER, HERBAL VITAMINS, MINERALS, CALCIUM REPLACEMENT:

____

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO

PLEASE LIST: ____

ARE YOU ALLERGIC TO LATEX, METALS OR SENSITIVE TO JEWELRY? YES / NO

PLEASE LIST:____

ALLERGIC TO DENTAL ANESTHETICS? YES / NO

PLEASE LIST: ____

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PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

HIGH BLOOD PRESSURE, DIABETES, HEART MURMUR, MITRAL VALVE PROLAPSE, PACEMAKER, HISTORY OF STROKE, HEART BY-PASS, HEART STENT, A-FIB, RHEUMATIC FEVER, ANEMIA, BLOOD DISEASE, CANCER, KIDNEY OR LIVER DISEASE, TUBERCULOSIS, ASTHMA, EMPHYSEMA, AQUIRED IMMUNE DEFICIENCY.

JOINT REPLACEMENT (DATE OF REPLACEMENT) ____

ARE YOU REQUIRED TO PRE-MEDICATE? YES / NO

ANY OTHER CONDITIONS WE SHOULD BE AWARE: ____

WHO MAY WE THANK FOR REFERRING YOUTO OUR PRACTICE:_______________________________________

PLEASE PROVIDE YOUR DRIVERS LICENSE SO THAT WE MAY MAKE A COPY

A COPY OF YOUR INSURANCE CARD/AND I.D. IF APPLICABLE.

WE GLADLY FILE YOUR DENTAL INSURANCE AT THE TIME OF APPOINTMENT. ALL CLAIMS ARE SENT ELECTRONICALLY. UPON VERIFICATION OF BENEFITS, YOU ARE RESPONSIBLE FOR CO-PAYMENTS, DEDUCTIBLES, OR BENEFITS NOT COVERED BY YOUR INSURANCE PLAN. FOR MAJOR WORK, SUCH AS CROWNS, ROOT CANALS, AND PERIODONTAL TREATMENT REQUIRE A PRE-DETERMINATION.

I AGREE TO THE ABOVE, AND RESPONSIBLE FOR ANY PAYMENTS NOT COVERED BY MY DENTAL INSURANCE.

SIGNATURE: ____ DATE: ______________________

PAYMENTS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT VISA, MASTER CARD, DISCOVER, DEBT CARDS, AND HEALTH SAVINGS.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT PLEASE CALL OUR OFFICE 24 HOURS PRIOR TO YOUR DENTAL APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A $35.00 MISSED APPOINTMENT FEE.

SIGNATURE: ____ DATE: ______________________

WE WELCOME YOU TO OUR PRACTICE. IF YOU HAVE ANY QUESTIONS PLEASE DON'T HESITATE TO ASK.

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Patient Consent Form

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROCTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP AMONG THE MULTIPLE HEALTH-CARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD-PARTY PAYERS
- CONDUCT NORMAL HEALTH-CARE OPERATIONS SUCH AS QAULITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS

I HAVE BEEN INFORMED BY YOU OF YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF USES AND DISCLOSURES OF MY HEALTH INFORMATION. I HAVE BEEN GIVEN THE RIGHT TO REVIEW SUCH NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS LISTED ABOVE TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DICLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATRIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANYTIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____

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New Policy Effective August 1, 2018

As a patient, it is your responsibility to verify that we are indeed a participating provider with your insurance company/ network and what services are covered. ______ **(Patient initial)**

Please be advised that you are ultimately responsible for any and all balances incurred, regardless of insurance coverage. As a courtesy to you, our office will file to your primary insurance. However, it is the responsibility of the patient to be aware of their insurance benefits. **It is our office policy to collect any co-pays and deductibles at the time of service. Without a predetermination for restorative services, root canals, denture and/or related procedures, or extractions, payment must be made in full by the patient at the time of service.** Once payment is received, your account will be credited. Predeterminations can take anywhere from 1-6 weeks to process. ______ **(Patient initial)**

Please be aware that although your insurance carrier might state that some procedures are "eligible" for payment, or are a "covered benefit" that does not mean that there will be no financial obligation by you, the patient. Many times a deductible will be withheld, or there may be a separate co-payment withheld, depending on your specific carrier. Again, it is ultimately the responsibility of the patient, to know and understand their individual policy. ______ **(Patient initial)**

All insurance companies state a disclaimer: There is no guarantee of payment. Every claim is subject to medical necessity and the terms of your contract at the time services are rendered. One we receive the "explanation of benefits" (EOB) we must abide by their payment and/ or denial; therefore any remaining balance will be billed to you. Any disputes of the benefits should be addressed you your insurance company. Your account will be delinquent if payment is not made in a timely manner. ______ **(Patient initial)**

By my signature below, the undersigned patient assigns the rights and benefits of insurance under the applicable insurance policy for any service and/or charges provided by the providers of Conte Dental Associates. I hereby direct the benefits be paid directly to the office of Dr. Conte on my behalf for any services furnished to me by the providers of Conte Dental Associates. By my signature below, I hereby certify that I have read and fully understand all of the words and information contained in this form and reaffirm my consent to the examination, diagnostic procedure and/ or care, treatment, therapy or remedy proposed.
By my signature below, I permit a copy/fax of this form to serve as an original signature of authorization.

Please feel free at any time to discuss any concerns or questions you may have with our front office staff.

Patient Name: ____ **Date of Birth:** ______________________

Patient Signature: _____________________________________ **Date:** _____________________________

Witness Signature: ____________________________________ **Date:** _____________________________