MAGNOLIA FAMILY Dental

Welcome!

Welcome to our practice! We appreciate the trust you have shown in us by selecting our office to provide your dental care. We are committed to providing you with quality dental care in a caring, gentle manner.

Following, you will find our patient information form, including health history, office financial policy, our Notice of Privacy Practices and acknowledgement for the NOPP. Please take the time to fill out these forms completely and accurately; this will ensure your allotted time will be maximized.

When we make appointments, your scheduled time is for you and the doctor. If for some unforeseen reason you must change your appointment time, please give us 48 hours' notice. We understand that things happen unexpectedly, and we will try to accommodate today's busy schedules.

Thank you again for choosing us for your dental care!

4121 NW 37th Place • Gainesville, FL 32606 • (352) 373-7361 • Fax (352) 373-7150
www.magnoliafamilydental.com

Welcome to Our Practice

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date_____ Home Phone_____ Cell Phone_____

Mr. Mrs. Ms. Dr. Name_____ Preferred Name_____
Last First Initial

Address_____ Apt #_____ Soc. Sec. #_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Child ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

EMAIL ADDRESS _____

Patient Employed by_____ Occupation_____

Business Phone_____ Ext._____ Whom may we thank for referring you?_____

In case of emergency, who should be notified? _____ Relationship_____ Phone #_____

Acct. Info

Person Responsible for Account_____ Relationship_____

Address (If different from patient)_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Dental Insurance

Subscriber_____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Employer _____

Insurance Company _____ Ins. Phone #_____

Contract #_____ Group #_____ Subscriber # _____

Dependents covered on this plan _____

Please Complete Both Sides

Health History

Dental History

Reason for Today's Visit _____

Former Dentist _____ Phone # _____

Date of last dental care _____ Date of last dental X-rays _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Jaw pain
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth
- ☐ Chewing gum habit
- ☐ Fingernail biting habit
- ☐ Other _____

Medical History

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Physician's Name _____ Phone # _____ Date of your last visit _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ AIDS
- ☐ Acid Reflux
- ☐ Artificial Joints
  - ☐ Premedication for Dental Treatment
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Problems
  - Describe _____
- ☐ Hemophilia
- ☐ Hepatitis Type _____
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pace Maker
- ☐ Persistent Cough
- ☐ Radiation Treatment
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Venereal Disease

MEDICATIONS ☐ Yes ☐ No IF yes, list ALL MEDICATIONS REASON

DRUG ALLERGIES ☐ Yes ☐ No

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

Authorization

Signature _____ Date _____

MAGNOLIA FAMILY Dental

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Twyla J. Roberts, DMD

this _____ day of _____, 20_____.

A copy of this signed, dated Acknowledgement shall be as effective as the original.

I give my permission to discuss my dental treatment with the following person(s):

_____

_____ _____

Please **print** your name Please **sign** your name

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority _____.

You May Refuse to Sign This Acknowledgment

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer at (352)-373-7361.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

4121 NW 37th Place, Gainesville, FL 32606

352-373-7361

MAGNOLIA FAMILY Dental

OFFICE FINANCIAL POLICY

As your dental professionals, we are committed to providing you with the best possible dental care. In order to achieve this goal, we need your assistance, and your understanding of our financial policy.

PAYMENT FOR SERVICE IS DUE AT TIME SERVICE IS RENDERED. We accept cash, personal checks, and all major credit cards. Returned checks are subject to a service charge of $35.00.

CHANGE OF APPOINTMENT: PATIENTS WHO DO NOT GIVE AT LEAST 2 BUSINESS DAYS' NOTICE WHEN CANCELING OR RESCHEDULING APPOINTMENTS WILL BE CHARGED A BROKEN APPOINTMENT RANGING FROM $75 TO $200. **INITIAL** _____

FINANCIAL AGREEMENT: We will gladly discuss your proposed treatment and do our best to answer any questions related to it. You must realize however:

We do not offer any in-office payment plans; however, payment arrangements can be made through Care Credit.

Any account balance not paid within 30 days will incur a finance charge. Account balances unpaid after 90 days will be sent to an outside collection agency.

We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, you must contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help.

I have read and understand the above financial policy.

_____ _____

Signature Date

PATIENT PHOTOGRAPH CONSENT

I give Magnolia Family Dental to use my "before" and "after" photos for educational and marketing purposes.
My name will not be used and only the lower portion of my face will be included.

_____ _____

Signature Date

MAGNOLIA FAMILY Dental

INSURANCE AGREEMENT

Most importantly, please know our treatment is based on the dental needs of the patient, not the insurance company benefits.

1. As a service to our patients, *we will do our best to* ***estimate*** *what your insurance company will pay.* We will file your claim for you and we will collect your deductible, co-payment and fees for any non-covered services at the time of service.
   We are not responsible for how your insurance company pays your claim. We cannot possibly know every clause in your dental contract.
2. **As a patient, I am aware that the office of Dr. Roberts *is* an in-network contracted PPO provider for *Sunlife Financial, Aetna, Cigna Radius, GEHA Federal,* and *Blue Dental Choice Plus* only.** **INITIAL** _____
3. All other insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract in any way. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services that they *will not* cover. Whether your insurance plan pays based on a fee schedule, allowance, or usual and customary, *you may receive a statement for the portion your insurance did not cover, even after you paid your co-payment.* If your insurance fails to pay their portion within 75 days from the date of service, the entire balance will be due from you. You can then obtain reimbursement from your insurance company.
4. For any account 30 days past due a monthly finance charge will be applied unless prior arrangements have been made
5. Accounts with a balance over 90 days will be sent to an outside collection agency. Any service fee incurred by the agency will be your responsibility

I _____ agree to accept the standard fees of this office despite my insurance benefit agreement. I am aware that there may be a difference in the insurance plan fee and the standard fee.

Any questions regarding your insurance coverage, please feel free to ask.

_____	_____	_____
Name (Printed)	Signature	Date

DELTA DENTAL PATIENTS: Please be aware that these companies do not send payment to an out of network provider. Therefore, full payment of services rendered is expected on the date of your visit.