17178 Toledo Blade Blvd
Port Charlotte, FL 33954
941-625-7877

Welcome!

So we may provide you with the best possible care and get to know you better, please complete these personal information, medical & dental history forms. All information is confidential.

Date: ________________________________

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr. Preferred to be called:____________________

Name: First______________________Last_________________________MI____________

Address____

City____________________________________State_____________Zip______________

Home Phone: ____________________________Cell:______________________________

Work:
__________________________________Email:______________________________

Date of Birth: _____/_____/_____Social Security #______________________ Sex: M F

Marital Status______________ Whom may we thank for referring you? __________________

Physician's name: _________________ Phone #_______________Date of last visit________

Preferred Pharmacy__________________________ Phone #_________________________

Emergency Contact: _________________________ Phone #_________________________

<u>Employment Information</u>

Employer: ______________________________Occupation:__________________________

Spouse's Name: _________________________ Occupation: _________________________

Spouse's Employer: ______________________ Work Phone: _________________________

Insurance Information

Insured's Name: __________________________ Employer__________________________

Insured's Social Security #___________________ Date of Birth_____/______/_______

Insurance Company: _______________________ Group #____________________________

Person Responsible For Account

Name: ___________________________Phone #_____________ Relationship____________

Social Security #____________________ Billing Address____________________________

Patient Medical History

This questionnaire will be used by your dentist to help treat you safely. Please answer all questions as accurately as possible.

Do you have or have you had any of the following? (Please circle one)

Aids/HIV	Y / N	Hepatitis/Jaundice	Y / N
Allergy to Latex	Y / N	High Blood Pressure	Y / N
Anemia	Y / N	Irregular Heart Beat	Y / N
Chest Pain	Y / N	Kidney Disease	Y / N
Arthritis	Y / N	Liver Disease	Y / N
Artificial Joints	Y / N	Mitral Valve Prolapse	Y / N
Asthma	Y / N	Organ Transplant	Y / N
Bleeding disorder	Y / N	Pacemaker/Defibrillator	Y / N
Cancer	Y / N	Artificial Heart Valve	Y / N
Chemotherapy	Y / N	Psychiatric Treatment	Y / N
Colitis/Intestinal	Y / N	Radiation Therapy	Y / N
Diabetes	Y / N	Renal Dialysis	Y / N
Emphysema	Y / N	Rheumatic Fever	Y / N
Epilepsy/Seizure	Y / N	Sexually Transmitted Disease	Y / N
Heart Attack	Y / N	Stomach Ulcer	Y / N
Heart Disease	Y / N	Stroke	Y / N
Heart/Bypass Surgery	Y / N	Thyroid Disease	Y / N
Heart Murmur	Y / N	Tuberculosis	Y / N

Have you ever taken an appetite suppressant? (Such as Fen-Phen)________________________

Do you smoke tobacco? ______ How much do you smoke? __________ How Long? __________

Do you use alcohol? _______How Many per week? _________ Recreational Drugs? __________

Are you pregnant? ______ How many weeks? ____ Are you taking birth control? _____________

Please List Any Allergies: ____

____

Please List Any Medications: ____

____

____

Consent for Treatment

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent of guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Patient Signature: ___________________________________ Date: ___________________
(Parent/guardian signature if patient is a minor)

Dental History and Smile Analysis

When was your last dental appointment? _________ Last Dental Hygiene Visit? ____________

Last Dental X-rays? _________ Are you having any problems at this time? ________________

Are your teeth sensitive to any of the following? Heat Cold Sweets Biting

Have you ever been treated or told that you have gum disease? __________________________

Have you ever experienced: (please circle)

Discomfort, popping, clicking or locking of your jaw?	Yes	No
Pain upon chewing, opening wide or yawning?	Yes	No
Grinding or clenching your teeth?	Yes	No
Frequent headaches, neck or shoulder aches?	Yes	No
Loose teeth or changes in your bite?	Yes	No
Do you have a night guard?	Yes	No

On a scale from 1-10 how would you rate your: Dental Health_____ Your Smile_____

Is there anything that concerns you about your smile? (color, spaces, chips, old crowns/fillings, etc…) If so how would you like to see your smile change? ______________________________

____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Dietrich Dental Services, PA this ____ day of ___________________, 20_____. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_______________________________ ___________________________________

Please print your name Please sign your name

If you are the legal representative of the patient, please print the patients' name and describe your authority____

I give permission for Dietrich Dental Services, PA to disclose information to the following:

____

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer.

Office Use Only

I attempted to obtain the patient's (or representative's) signature on this acknowledgement but I 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 ( ) Other ( ) _______________________________

Signature of Privacy Officer: ____

Dietrich Dental Services, PA
17178 Toledo Blade Blvd.
Port Charlotte, FL 33954

Financial Policy

We appreciate the opportunity to serve you! We've found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

- **Patients without insurance coverage need to know....**
  The fee for treatment rendered must be paid in full on the day of service.

- **Patients with insurance coverage need to know....**
  The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all fees generated by your treatment.

- **We accept Visa, MasterCard, Discover, American Express, Cash and Checks for payment of the amount due.** Payment plans are available through Care Credit. Please ask if interested.

- **Deposit Policy**.... Due to the extensive amount of time our staff and Doctors devote to preparing for your reserved time we require a deposit of half of the treatment fee for a reserved appointment over $1000.00.

- **Two business days' notice is required for rescheduling appointments.** A **$75** to **$100** fee, depending on the amount of time that was reserved for you, will be applied to your account for rescheduling, canceling or failing to show up for your appointment without 2 business days' notice. Dr. Dietrich and Dr. Kalonaros reserve your appointment time exclusively for you; they do not "over-book" and keep extra patients waiting in case you can't come. Please be considerate.

This is an agreement between Dietrich Dental Services, PA, as creditor, and the Patient/Debtor name on this form. By executing this agreement, you consent to treatment by Dr. Dietrich, Dr. Kalonaros and their team and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

The Financial Policy continues on the next page.

Patient's Name______________________________________

Responsible Party
(under 18 years old)__________________________________

Signature: _______________________ Date: _______________

In this agreement the words “you”, “your”, and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to Dietrich Dental Services, PA.

Treatment Plans: You understand that if the Doctor has treatment recommendations for you, you will receive an itemized list of the recommended treatment. This will also contain an estimate of what the fees will be for the recommended treatment. If you have dental insurance, the treatment plan may include an additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. You understand that treatment plan estimates are not a guarantee of insurance payment and you are ultimately responsible for all fees generated by your treatment.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued, and is overdue if not paid by 21 days after the statement date.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within 90 days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of (1.0%) per month. The finance charge is computed by applying the periodic rate (1.0%) to the overdue balance of your account. The “overdue balance” of your account is calculated by taking the balance owed 90 days ago, and then subtracting any payments or credits applied to the account during that time.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection to the balance of a lawyer, you agree to pay all lawyers’ fees that we incur plus all court costs.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, or we have to litigate in court. If your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become public record.

Returned Checks: There is a fee (currently $35) for any check returned by the bank.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service.

Insurance Release: Your authorize Dietrich Dental Services, PA to release any necessary information requested by your insurance carrier and authorize payment directly to Dietrich Dental Services, PA for any benefits available under your insurance plan.

Insurance: Insurance is a contract between you and your insurance company. We will bill your insurance as a courtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within 90 days after the date of service, the full amount is due and payable by you. We will promptly refund you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

Patient signature: ______________________________________ Date: _____________

(Parent or guardian signature for minor)

Authorization for Photography

Clinical photography is an extremely important facet of treatment. In our practice we use photography frequently to enhance the outcome of your clinical treatment. In addition, because we provide education to both consulting patients and other dentists, we may use photography to assist in education the layperson and the profession. This document is to inform you of the specific situations we may use photography and request your approval to use your photographs in certain educational environments.

1. New patients contemplating prosthodontic treatment in our office will benefit from a comprehensive evaluation. In addition to appropriate history taking, data collection, radiographs, study casts, and clinical evaluations, diagnostic photography is essential for proper evaluation and treatment. It documents pre-operative conditions for your permanent record as well as allowing us to review your dental condition without you actually having to be here! In fact, we find it below the current standard of care if not impossible to completely evaluate, diagnose and treatment plan your dentistry without photographs.
During your new patient evaluation, a standard series of photographs will be made. These will be placed in your permanent record as a digital image and are available to you in print form or on CD at any time. We may also share these images with any dentist or physician that is on your treatment team in order to better communicate and treat your condition.
During treatment, photographs may be taken to document certain intra-operative conditions. These too may be shared with the treatment team in order to help better your treatment outcome. We will also share certain images with our dental laboratories in order to communicate shade, position and overall look of your teeth to ensure the best possible cosmetic outcome. Post-operative photographs may be taken to permanently document outcome for your record.
Much like Gastroenterologist uses and endoscope or an Orthopedic Surgeon uses an arthroscope to photograph and document their findings, we find it essential to photograph your dentistry. When used as described above, we receive no financial remuneration for these photographic images. Used in the capacity described above, these images are not used for additional education purposes. This portion of the authorization is not requesting your authorization for photography; it is simply informing you of the use of photographic images in the fashion described above.

Signed____Date______________________

2. Because we are specialist and educators, we interact and teach dental students, residents, practicing dentists and their staff. If your situation qualifies as a condition with educational value, we would like to use your images in education. With your signature, this authorizes us to use photographs of your dentistry to educate the profession. We may use these photographs for an indefinite period of time to show long-term case studies. Because this process involves continuing education, Drs. Dietrich and Kalonaros disclose that they may be compensated for their contribution to continuing education.

Signed____ Date_________________________

3. Patients experiencing extensive dental treatment can benefit from photographic documentation of potentially similar dentistry. Your signature gives your consent to show photographs of your dentistry to other patients. This will greatly enable them to understand in a visual capacity, the conditions or processes they have or can expect during treatment. We may use these photographs for an indefinite period of time to show long-term case studies. Drs. Dietrich and Kalonaros receive no compensation for the use of these photographs.

Signed____ Date_________________________