PATIENT INFORMATION (CONFIDENTIAL)

Name_____Date_____
First Middle Last

Address_____

Home Phone _____ Work Phone_____

Cell Phone_____

Email Address that you check daily –to be used for confirming appointments_____

Social Security#_____ Birth Date_____

Occupation_____

Check Appropriate __Minor __Single __Married __Divorced __Widowed __Separated

If College Student FT/PT, Name of
School_____

Patient's or parent's employer_____

Business Address_____

Spouse or Parent's Name_____

Person to contact in case of an emergency_____

RESPONSIBLE PARTY

Name of person responsible for this account_____ Relationship to patient_____

Address_____ Home or cell phone_____

Employer_____ Work Phone_____

Name of insured_____ Relationship to patient_____

Name of Insurance Co_____

Birth Date_____

X_____ Date_____

Signature of Patient or parent if minor

Child Health/Dental History Form

ADA.
American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Dr. Cristene Maas
Financial Policy

Thank you for choosing Family Dentistry as your dental health care provider. The doctor and her staff are committed to providing you with the best in dental health care. In order to achieve this goal, we need your understanding of our Financial Policy. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we requires you to read and sign prior to any treatment.

- All Patients must complete our information and insurance form before seeing the dentist.
- Full Payment is due at time of service
- We accept cash, checks, Visa, Mastercard, Discover and American Express. By law we may charge a fee for returned checks or chargeback, currently $30.00

Participating Healthcare Insurance Plan Obligation

We maintain a list of the Healthcare plans which we have contracted to provide services to patients. We have agreed to bill those insurance carriers for all services rendered. Authorization from your insurance company does not always guarantee full payment. The undersigned and/or patient shall remain responsible for all charges, applicable co-pays and deductibles. ***If your insurance has not responded to our claim submittal within 60 days, payment for services incurred, and claim status follow up becomes the responsibility of the patient.***

Non-Participating Insurance

We will gladly help you in filing your insurance claim to your insurance carrier. However, there will be a co-pay due at the end of each visit. This co-pay is only an estimate of your portion, since we are Non-Participating, we can not predicted the total fee for services.

PPO/Traditional Insurance Waiver Regarding Non-Covered Services

Most health insurance plans will only pay for services that they determine to be "reasonable and necessary." If they determine that a particular service is not "necessary" under their program standards, or that the services were unauthorized, or not a covered benefit under your plan, they will deny payment for those services. The undersigned and/or patient, understand and agree to be personally responsible for payment for all non-covered services as determined by your plan.

Minor Patients

An adult accompanying a minor and or parent or guardian for the minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment. We are not party to any divorce decree or other legal judgments that outlay responsibility for medical payments.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and our charges are at or below the "usual and customary" for our area.

Interest on Past Due Accounts and Collections Policy

Interest will be charged on balances unpaid 90 days from date of service at a rate of 18 percent per annum (1.5% per month), and any account that is unpaid for a period of 120 days from the date of service will be placed for collection. Should collections become necessary, the patient, or the patient's responsible party, will be responsible for all collections cost and attorney's fee there from.

Thank you for understanding our Financial Policy. Please let me know if you have any questions or concerns.

I have read the Financial Policy and I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or responsible Party Date

Cristene Maas, DDS, PA, Clinic Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Cristene Maas, DDS, PA, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Jill Jones, at (123) 456-7890 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of Cristene Maas, DDS, PA, Notice of Privacy Practices.Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____

Family Dentistry

Dr. Cristene Maas
3030 East Semoran Blvd.
Suite 200
Apopka, FL 32703
(407)788-6888

To: All Current and New Patients

From: Dr. Cristene Maas

Re: $50.00 fee for Missed Appointments

In order to provide quality and effective patient care, control costs, and keep our fees at the lowest possible rates, we must charge a "No Show" fee for failed appointments. Effective immediately, your account will be charged a fee of $50.00, should you fail to notify this office, at least 24 hours prior to your scheduled appointment, of your need to cancel or reschedule.

If you need to cancel or reschedule, you must notify the front desk between the hours of 7:30am and 3:30pm, 24 hours prior to appointment, Monday-Thursday.

I have read the above policy and I understand a fee of $50.00 will be charged to my account should I miss my scheduled appointment and fail to notify the office in accordance with the appointment cancellation policy.
Fee is subject to change without prior notice

_____ _____
Patient Signature *Date*

_____ _____
Staff Signature *Date*