Windermere Center for
DENTISTRY

401 Main Street, Suite A
Windermere, FL 34786
(407)909-1097

Patient Information

Patient Name _____ **Preferred Name** _____

Phone (Home) _____ **Date of Birth** _____

Phone (Work) _____ **Email Address** _____

Phone (Cell) _____ **Sex:** **Male** ◯ **Female** ◯ **Marital Status** _____

Home Address _____ **City/State/Zip** _____

Emergency Contact Information:

Name _____ **Relationship** _____ **Phone** _____

Name of Primary Care Physician _____ **Phone** _____

Please list other members of your immediate family who are patients in our office: _____

Referring Information:

Who can we thank for referring you?

Family Member: _____

Coworker: _____

Friend: _____

Doctor: _____

Or did you find us on your own?

Our Website ☐ **Other** _____

Southwest Bulletin ☐

Insurance Provider ☐

Yellow Pages ☐

Dental Insurance Information:

Name of Guarantor/Insured _____ **Relationship to Guarantor** _____

Guarantor's Date of Birth _____ **Guarantor's Social Security #** _____

Guarantor's Employer _____ **Guarantor's ID #** _____

Insurance Company_____ **Insurance Company's Phone #** _____

Date of last dental cleaning _____ **Do you suffer from dental anxiety?** Yes ◯ No ◯

Have you ever had any complications or allergic reactions following dental treatment? Yes ◯ No ◯

If yes explain: _____

Are you under a physician's care now? Yes ◯ No ◯ _____

Have you ever been hospitalized or had any major operations? Yes ◯ No ◯ _____

Have you ever had a serious head or neck injury? Yes ◯ No ◯ _____

Are you on a special diet? Yes ◯ No ◯ _____ **How long?** _____

Do you use tobacco products? Yes ◯ No ◯ _____ **How long?** _____

Do you use a controlled substance? Yes ◯ No ◯ _____

If you could change anything about your teeth, what would it be? _____

Are you aware of clenching or grinding your teeth? ____◯ ◯_____

Do you wake up with a headache? _____◯ ◯_____

Do you wake up with jaw or neck pain? _____◯ ◯_____

Are you aware of snoring when you sleep? _____◯ ◯_____

Why did you leave your previous dentist? _____

Female Patients-are you: ☐ **Nursing?** ☐ **Taking oral contraceptives?** ☐ **Pregnant/Trying to get pregnant? Due date** _____

Are you allergic to: ☐ **Penicillin** ☐ **Codeine** ☐ **Acrylic** ☐ **Latex** ☐ **Local Anesthetics** ☐ **Nickel** ☐ **Sulfa** ☐ **Other** _____

Do you have, or have had, any of the following?

☐ AIDS/ HIV Positive	☐ Diabetes	☐ Herpes	☐ Rheumatic Fever
☐ Alzheimer's disease	☐ Drug Addiction	☐ High Blood Pressure	☐ Rheumatism
☐ Anaphylaxis	☐ Easily Winded	☐ Hives or Rash	☐ Rheumatoid Arthritis
☐ Anemia	☐ Emphysema	☐ Hypoglycemia	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ Irregular Heartbeat	☐ Scoliosis
☐ Artificial Joint	☐ Excessive Bleeding	☐ Kidney Problems	☐ Shingles
☐ Asthma	☐ Excessive Thirst	☐ Leukemia	☐ Sickle Cell Disease
☐ Blood Disease	☐ Fainting Spells/ Dizziness	☐ Liver Disease	☐ Sinus Trouble
☐ Blood Transfusion	☐ Frequent Cough	☐ Low Blood Pressure	☐ Spina Bifida
☐ Breathing Problem	☐ Frequent Diarrhea	☐ Lung Disease	☐ Stomach/ Intestinal Disease
☐ Bruise Easily	☐ Frequent Headaches	☐ Mental Disorders	☐ Stroke
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Swelling of Limbs
☐ Chemical Dependencies	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Chemotherapy	☐ Heart Attack/ Failure	☐ Parathyroid Disease	☐ Tonsillitis
☐ Chest Pains	☐ Heart Murmur	☐ Prolonged Bleeding	☐ Transplant/Prosthesis
☐ Cholesterol-High/Low	☐ Heart Pace Maker	☐ Psychiatric Care	☐ Tuberculosis
☐ Cold Sores/ Fever Blisters	☐ Heart Trouble/ Disease	☐ Radiation Treatment	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Hemophilia	☐ Recent Weight Loss	☐ Ulcers
☐ Cortisone Medicine	☐ Hepatitis	☐ Renal Dialysis	☐ Venereal Disease

If yes to any of the above please explain. _____

_____

Have you ever had any serious illness not listed above? Yes ◯ No ◯ **If Yes, please explain:** _____

_____

List any medications you are currently taking (include over-the-counter drugs or vitamins): _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian _____ **Relationship** patient **Date** _____

HIPPA Acknowledgement & Authorization

I hereby authorize my insurance company or any other third party payer to pay directly to Windermere Center for Dentistry all charges submitted for services incurred by me. I understand that I will be responsible for any and all charges not paid by my insurance company or third party payer. I authorize Windermere Center for Dentistry to release information concerning my dental/medical condition to my insurance company, employer, attorney or multiple health care providers who may be involved in the treatment directly or indirectly. I assign payment directly to the doctors at Windermere Center for Dentistry which may cover in whole or part of the dental services that I have received. The authorization shall be valid until I notify Windermere Center for Dentistry in writing of a cancellation. A photo copy of the authorization shall be as valid as the original copy.

I hereby acknowledge that I have read the HIPPA Privacy Policy and understand my rights contained in the notice. By way of my signature, I provide Windermere Center for Dentistry with my authorization and consent to use and disclose my protected dental/health care information for the purposes of treatment, payment and health care operations as described in the HIPPA Privacy Policy.

Signature of patient, parent or guardian _____ **Relationship** ___patient___ **Date** _____

Office Policy

Effective September 1, 2009 there will be a $50 fee per hour scheduled for same day or short notice cancellations and missed appointments. There is no charge for cancellations that are made at least 24 business hours before the day of the scheduled appointment. Our normal business hours are Mondays & Wednesdays 9am-6pm and Tuesdays & Thursdays 8am-5pm. Our office is closed on Fridays. Messages left via voicemail will NOT be counted as an official cancellation notice. THESE FEES ARE NOT COVERED BY INSURANCE CARRIERS; IT WILL BE THE FAMILY'S RESPONSIBILITY TO PAY. Payment in full is required before any future appointments can be made. Patients with a chronic history of failed or broken appointments will have to call the day of to see if times are available since our office will no longer be able to reserve appointments in advance.

Signature of patient, parent or guardian _____ **Relationship** ___patient___ **Date** _____

Insurance

In order to meet the need of our patients, we have enrolled in various insurance programs. As you can imagine, keeping up with all of the individual requirements for each of the insurance companies can be practically impossible. Each program may have different requirements or stipulations that dictate which services can be provided and how often they can be provided. These rules can vary even in the same company with various programs being offered. At Windermere Center for Dentistry, providing the highest quality in dental car to our patients in an atmosphere of genuine caring is our primary concern. It is possible that your insurance provider may NOT cover every service we provide in our office, and in these cases, we will have no choice but to bill you for the services provided. It is not our sole responsibility to know every detail of your particular insurance policy so if we work together, both doing our parts to familiarize ourselves with your specific policy, we can focus on what we do best-take care of you.

I understand that my insurance company may disallow and not pay fees related to certain procedures and services that I may receive at this office. If these are disallowed, I understand that I am responsible for payment. I understand that I am also responsible for any balance that is not paid by my insurance company after 30 days.

Signature of patient, parent or guardian _____ **Relationship** ___patient___ **Date** _____