Centergate Family Dentistry

Juan C. Mesia D.D.S.
4076 Cattlemen Rd. • Sarasota • Fl • 34233 • (941) 379-7777

Welcome, so we may provide you with the best possible care and get to know you better; please complete this Medical & Dental History Form. Please keep in mind that all information is kept Confidential.

Date: _____

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr. Preferred Name: _____

Name: _____
First Middle Initial Last

Address: _____
City State Zip

Home Phone: _____ Cell: _____

Work: _____ Email: _____

Marital Status: _____ Social Security #: ____/____/____

Sex: Male or Female D.O.B.: ____/____/____

Parent or Responsible Party: _____ DOB: _____

Insurance Information

Please fill this section out using the subscriber's information

Insured Person's Name: _____ D.O.B.: ____/____/____

Employer's Name: _____ Social Security#: ____/____/____

Insurance Company: _____ Group #: _____

Employment Information

Employer: _____ Occupation: _____

How did you hear about us?

Yellow Pages ( ) Walk-In ( ) La Guia ( ) Mailer: Postcard ( ) /Coupon ( )

Internet Search ( ) Insurance ( ) _____ Other ( ) _____
Company

Employee / Friend ( ) _____
Name of Patient or Person that referred you

Time 1:13 PM

Centergate Family Dentistry

Eaglesoft Medical History

Date 6/17/2016

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin, Penicillin, Codeine, Acrylic, Metal, Latex, Sulfa Drugs, Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

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:

X_____ Date:_____

Dental History . . .

Are you currently having any Dental Problems atthis time? _____

When was your last Dental Appointment? _____

Date of Last Cleaning:_____ Date of Last X-rays: _____

Previous Dentist: _____
Name Location Phone #

What didn't you like about your previous office? _____

How often do you:

Brush _____ **Floss** _____ **Whiten** _____

See your Hygienist for cleanings? _____

Have you ever been told/treated for Periodontal Disease? Yes No Date: _____

What dental products are you using athome? _____

Are your teeth Sensitive to:

Heat: Yes No **Cold:** Yes No **Sweets:** Yes No **Biting:** Yes No

Do you notice?

Bleeding upon brushing?	Yes	No	Gum Recession?	Yes	No
Swelling of the Gum Tissue?	Yes	No	Bad Breath/Taste?	Yes	No
Frequent Headaches	Yes	No	Loose Teeth	Yes	No

Discomfort/Popping/Clicking of your Jaw? Yes No

Grinding or Clenching of your teeth? Yes No

Do you have a Night Guard? Yes No

On a Scale of 1-10 how would you rate your:

Smile:_____ Dental Health: _____

Would you like your teeth: Whiter: Yes No Straighter: Yes No

If you could change one thing about your smile what would it be?

_____

What can we do to make your visit more comfortable?

_____

Privacy Notice and Consent

Centergate Family Dentistry, Juan C Mesia, DDS and Associates; believes our patients have the right to Privacy and that their personal financial and health information should be kept confidential. Our belief in your right to privacy is nothing new. However, new laws now require that we notify you about our privacy in writing.

How do we use your personal health information?

We will use your personal health information to provide, coordinate, or manage your dental treatment and any related services. This may include providing necessary information to pharmacy personal, laboratory technicians, or to third party health care providers. For example, we might need to disclose information, as necessary, to a home health agency that provides care to you, or to a physician or dental specialist to whom you have been referred to ensure that they have the necessary information to diagnose or treat you.

Personal information may be given to your insurance company if necessary to facilitate payment of your claims.

On occasion your personal information may be used for/in supporting the practices business operations. These activates include, but are not limited too, quality assessments activities, employee review activities, training of dental students, licensing, and conductions or arranging for other business activities. We may use a sign-in sheet at the receptionist desk where you will be asked to sign your name and indicate the practitioner you are to see. We may also call you by name in the reception area when ready to bring you back. We may use or disclose your protected health information, as necessary; to contact you to remind you of your appointment or discuss any questions we may have regarding youraccount.

We may also use or disclose your personal information in the following situations without your authorization as required by law: Public health issues/communicable diseases, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners request, research, criminal activity, national security, and workers compensation.

What are your rights?

- You have the right to inspect and copy your personal information
- You have the right to request a restriction of your personal information.
    - This means you may ask us not to use or disclose any of your personal information for the purposes of treatment, payment, oroperations.
    - You may also request that any part of your information not be disclosed to family members or friends who may be involved in your care or for that notification purposes as described in this Notice of Privacy Practices.
        - Your request must state the specific restriction requested, in writing, and to whom you want the restriction toapply.
- Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit the use and disclose of such information, it will not be restricted. You then have the right to use another Health Care Professional.
- You have the right to request/receive confidential communications from us by alternative means or at an alternative location.
- You may have the right to have your dentist amend your personal health information
- You have the right to receive an accounting of certain disclosures we have made, if any, of your personal health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object of withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You can be assured there will be no ill-will following a complaint by you.
This notice was published and becomes effective on/before December 10, 2010.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected personal/health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number (941)379-7777.

This is to certify that I have read and understand the above information. By signing this statement I am giving Centergate Family Dentistry, Juan C Mesia, DDS and its team member's permission to release my personal information as described above.

_____ _____

Signature of Patient / Legal Guardian Date

Office and Financial Policy

Welcome and thank you for choosing Centergate Family Dentistry for all your Dental needs. We are committed to providing you with the highest quality of dental care, in an efficient, timely, and cost effective manner. We hope that by providing you with our policies in advance you will have a great experience with our office and gain a better understanding of the financial obligation related to your dental treatment.

Treatment Plan

We have prepared for you an itemized Treatment Plan that outlines the sequence of dental services to be provided. The Treatment Plan reflects the clinical findings and standard of care procedures dentally necessary for you to attain the smile and overall dental health you are seeking. Due to the nature of dentistry, treatment and fees may change; if this occurs will inform you prior to rendering any services.

Estimated Fees

The Treatment Plan has an estimation of what we *expect* your insurance carrier to pay. Each insurance benefit plan is slightly different in its covered services; it is the insurance carrier's discretion for final payment. If you have any questions on your insurance coverage, please feel free to contact your insurance company or your Employer's Human Resources Department.

We understand that your insurance carrier may deny, adjust, or pay an alternate benefit; so as a courtesy to you, we will send a bill for the amount due. Your insurance carrier will provide an explanation of benefits. There may be a balance due after your claim is processed by your insurance carrier. As the policy holder and account guarantor, you are responsible for all fees not paid by your insurance carrier.

Insurance Benefits

As the insurance holder, you are responsible for knowing your insurance benefits and coverage. As a courtesy to you, we will accept the insurance assignment of benefit. We will gladly file your insurance claim on your behalf. We will allow 30 days from the date of service for the insurance company to pay. If the insurance carrier does not pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage/benefits (i.e. deductibles, non-covered services, co-insurance, pre-existing conditions, reasonable and customary charges, etc.) You are responsible for the timely payment of your account.

Payment Types

Payment of fees is due at the time services are rendered. For your connivance, we accept Cash, Personal Checks (with Identification), Visa, MasterCard, Discover, Care Credit, Chase Health Advance, and Springstone Financial.

There is a $35 fee for all returned checks.

Payment Plan and Financing Options

As convenience for you, we have made arrangements with Third-Party Healthcare Lenders to provide a financing option that will allow you to pay for your dental care over an extended period of time. This option is based on Approval. Please ask our Financial Specialist how you can apply.

No Shows and Cancellation Policy

48 hours notice is required for all cancellations. Each Patient is allowed **ONE** no show or cancellation without 48 hours notice without penalty. Any additional broken appointments will result in a $40 charge to your account.

Non-Payment Recourse and Disclosure

As a courtesy we do not charge interest on accounts until your account is outstanding past 90days. Any balances unresolved and outstanding past 90days without prior arrangements with our office will be sent to an Attorney or Collection Agency. A collection fee of 33% for balances less than 1 year; and 50% for balances over 1 year will be added to your account.

I have read, understand, and have agreed to the above office and financial policies. I hereby attest that I have given and agree to provide current personal, demographic, and insurance information and authorize release of information necessary to fill insurance and or collection of my account.

_____ _____

Signature of Patient / Legal Guardian Date

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Written Financial Policy

Thank you for choosing Centergate Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard or Discover Card

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $1000 or more.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Centergate Family Dentistry requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring more than 3 appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $1000 or more, a 10% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2] Patient portion of the bill is due at time of service.

A fee of $40 is charged for patients who miss or cancel an appointment without 48-hour notice.

Centergate Family Dentistry charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)