Welcome!

Thank you for selecting Sumter Landing Dental Care and our healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need any assistance, do not hesitate to ask-we will be happy to help.

Patient First Name_____ Middle Initial: _____ Last Name: _____

Preferred Name (if different from first) _____ Sex (circle one): Male Female

Date of Birth (MM/DD/YYYY): _____/_____/_____

Social Security Number: _____ Drivers License Number: _____

Address: _____City: _____State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Email Address: _____

Emergency Contact (Name): _____ Number: (_____) _____ Relation: _____

How did you hear about our office? _____

Responsible Party Information: Only complete if patient is less than 18 years of age, or needs a Power of Attorney for healthcare purposes.

Name: _____ Relation to Patient: _____

Social Security Number: _____ Phone Number: _____

Drivers License Number: _____ State Issued: _____

Insurance Information- Complete only if insured. Please provide information for primary insurance coverage, but provide cards for all active dental policies.

Name of Subscriber: _____ Date of Birth: _____

Patient Relationship to Subscriber (circle one): Self Spouse Child Other

Subscriber Employment status (circle one): Retired Full Time Part Time

Subscriber ID number (if none, please provide SSN): _____

Patient ID number (if different): _____

Employer (past or present-if none, write "Self"): _____

Insurance Company Name: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Communication Preferences:

At this time we are only offering communication through telephone calls. As we expand into other forms of communication, which would you prefer?

- ☐ Phone Call (if marked, please circle which phone line): **Home Cell Other:** _____
- ☐ Text Message (cell phones only)
- ☐ Email (please provide above)

Signature: _____ Date Form Completed: _____

Patient Name_____ Date_____

Medical History

If you answer yes, please fill in the blank space with more information:

Are you under a physicians care now? If yes: _____
Have you ever been hospitalized or had a major operation? If yes, what and when:

_____
Have you ever had a serious head or neck injury? If yes: _____
Are you taking any medications, pills, or drugs? If yes, please list ALL or provide a list we can copy:

_____
_____
Do you take, or have you ever taken Phen-Fen or Redux? If yes, which and when:

_____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?
If yes, which and when: _____

Please circle your answers below:

Do you take blood thinners? YES NO

Are you on Bone Medications? YES NO

Do you take pre-medication before dental appointments? YES NO If yes, for what? _____

Are you on a special diet? YES NO _____

Do you use tobacco? YES NO

Do you use controlled substances? YES NO If yes, what: _____

WOMEN: Are you (circle all that apply): 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
- ☐ ANY OTHER PLEASE LIST:_____
- ☐ NONE

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Continued

Please circle any that apply, if none please mark "None" under the list!!!!

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

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

☐ None listed

If any other, please List:

_____

_____

Comments: _____

_____

_____

_____

_____

Sumter Landing Dental
1050 Old Camp Rd, Suite 286
The Villages, FL 32162
352-674-9009

HIPAA CONSENT FORM

Purpose of Consent: By signing this form, you will consent to our use and disclosure of you and/or your spouse/dependant's protected health information to carry out treatment, payment activities, and healthcare operations. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this HIPPA CONSENT FORM. Our Notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices that will contain the changes. Those changes may apply to any of your protected health information.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting David Price, DDS, at the address listed above.

Right to Revoke: You will have the right to revoke this consent at any time by kindly giving us a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this HIPPA CONSENT FORM will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this HIPPA CONSENT FORM.

Please give names of any persons allowed to discuss your treatment and/or financial arrangements:

_____

_____

_____

I have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this form, I am giving my consent to your use and disclosure by me or my spouse/dependent's protected health information to carry out treatment, payment activities, and health operations.

_____
Print Name

_____
Signature of Patient/Legal Guardian Date

Insurance Consent

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1050 Old Camp Rd, Suite 286
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352-674-9009

We would like to welcome you to our practice. We look forward to providing you the highest quality dental care.

Please provide a copy of your current insurance card(s) and photo ID.

In order to better serve you, please familiarize yourself with your dental plan benefits, *not* medical benefits. Members should be aware of copayments, patient percentages, limitations, previous dental treatment, and/or frequencies. If you have any questions regarding the exclusions and/or limitations of your plan, please contact your dental plan member services.

I understand I am only able to utilize one dental *discount* plan, and cannot use it in conjunction with a dental insurance. This does not prohibit the use of two dental insurance policies, I.E. Primary and Secondary.

I understand that this is the dental facility I have chosen for myself and/or eligible dependents. I am aware that if the insurance information is not true or active, at time of service, I am responsible for all charges related to services provided at the usual and customary fees of this office. I agree to pay in full for all such charges.

I understand that the treatment plans given to me at this office is an estimation of my insurance coverage, and I am responsible for any monies- up to the total amount charged- not paid by my insurance policy.

I have provided any coverage that I am currently under, and understand that if there is coverage disclosed only after services are rendered, Sumter Landing Dental cannot provide that insurance compensation for the past services. Coverage must be disclosed prior in order for services to the eligible for compensation or discounts. This includes additional policies.

I authorize payment of insurance benefits directly to Sumter Landing Dental, PLLC. _____
(Please Initial)

No Insurance:

I do not have dental insurance at this time, but will provide any new coverage before the following appointment. I understand that I will be responsible for the payment in full, and, as previously stated, Sumter Landing Dental cannot provide coverage for insurances disclosed after the services are completed. _____ (Please Initial)

_____
Print Name

_____ _____
Signature Date

Appointment Cancellation Agreement

Sumter Landing Dental Care appreciates the confidence you have shown in choosing us to provide for your dental care needs. It is important for all patients to keep their dental appointments, and understand that missed appointments result in lost time that could have been used to provide care to another patient.

Rescheduling appointments

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we require all patients to call at least 24 hours in advance to cancel or reschedule any appointment.

Missed appointments

If you miss or cancel an appointment with less than 24 hours notice, a missed appointment note will be recorded in your account along with a $25.00 missed appointment fee. Your next appointment will not be scheduled until this fee has been paid.

I understand the dental appointment agreement and agree to follow the terms of the policy

_____

Patients Name (Please Print)

_____

Signature Date