ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,____ , have received a copy of this office's Notice of Privacy Practices.
(Print Patient's Name)

____
(Signature-Parent/Legal Guardian must sign if patient under 18)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐Individual refused to sign

☐Communications barriers prohibited obtaining the acknowledgement

☐An emergency situation prevented us from obtaining acknowledgement

☐Other (Please specify)

CONSENT FOR DENTAL TREATMENT

Patient's Name:____ DOB: _____________

1. I hereby authorize the Dentist at Ricard Family Dentistry and/or other such persons as he/she may appoint to perform any necessary dental; procedures as deemed appropriate as part of the dental treatment.
2. I understand that Dental treatment may include examination, prophylaxis, restorations, endodontics, x-rays, surgery and extractions for the purpose of maintaining, improving and/or restoring soft and hard tissue to a healthy state.
3. I hereby authorize and request dentists at Ricard Family Dentistry and/or such designees or assistants as may be selected by the doctor, to perform the following procedure as per dentists treatment plan.
4. I understand that the risks involved in the above described treatment or procedure(s) include but are not limited to bleeding, swelling, and sensitivity.
5. I understand that unforeseen conditions or circumstances may arise during the course of treatment: hence, I consent to and authorize the performance of any care, procedure or treatment not specified above that the dentist reasonably believes necessary or available as a result of unforeseen events.
6. Additionally, I consent to the administration of any local anesthetic that the dentist deems necessary. I understand that the risks involved with the administration of local anesthetics include but are not limited to: nerve injury, and stiffness of the jaw (trismus).
7. It has been explained to me the option of not using local anesthetic for my treatment.
8. I confirm that I have had the opportunity to ask any questions regarding the patient's care at the dental office and that all such questions (if any) have been answered fully and satisfactorily.
9. I certify that I have read this document and understand its contents. I acknowledge that dental treatment, associated risks and related dental education materials have been explained to my satisfaction.
10. This consent will remain in effect until I choose to terminate it.

Dental and Medical History

I certify that all of the preceding answers and information provided are true and correct to the best of my knowledge. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I understand that providing incorrect information can be dangerous to my health. I have read and understand the above questions. I will not hold at Ricard Family Dentistry and its affiliated general dentists, and auxiliary staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will inform at Ricard Family Dentistry without fail.

Assignment and Release

I and/or my dependent(s) assign directly to Ricard Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Ricard Family Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payers and/or health practitioners for the purpose of obtaining payment and determining insurance benefits payable for related services.

Consent for Services

I understand and consent to have any treatment done by the dentist after the procedure, the risks, the benefits, and the costs have been fully explained. These treatments include, but are not limited to x-rays, cleanings, periodontal treatments, fillings, crowns, bridges, extractions, root canals, implants, and/or dentures. As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. I understand that the fee estimates listed for this dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to you or your assignee to call me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to the content.

I have read and understand the above:

____Date______/______/_____

Patient/Representative Signature (Parent/Legal Guardian must sign if patient under 18)

Dentist signature:____ Date______/______/_____

Witness____ Date______/______/_____

Telephone consent obtained from:________________________________ Date______/______/____

HEALTH HISTORY

Patient Name____ Date_____ /_____/_____

Reason for today's visit?____

Please check every box if you have had any of the following:

	YES	NO		YES	NO		YES	NO
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Radiation treatment	☐	☐
Anemia	☐	☐	Fainting or dizziness	☐	☐	Respiratory disease	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Rheumatic fever	☐	☐
Artificial heart valves	☐	☐	Headaches	☐	☐	Scarlet fever	☐	☐
Artificial joints	☐	☐	Heart murmur	☐	☐	Shortness of breath	☐	☐
Asthma	☐	☐	Heart problems	☐	☐	Sinus trouble	☐	☐
Back problems	☐	☐	Hepatitis? Type	☐	☐	Skin rash	☐	☐
Abnormal bleeding?	☐	☐	Herpes	☐	☐	Special diet	☐	☐
Blood disease	☐	☐	High blood pressure	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Swollen feet or ankles	☐	☐
Drug/Alcohol addiction	☐	☐	Jaw pain	☐	☐	Swollen neck glands	☐	☐
Chemotherapy	☐	☐	Kidney disease	☐	☐	Thyroid problems	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tonsillitis	☐	☐
Congenital heart lesions	☐	☐	Low blood pressure	☐	☐	Tuberculosis	☐	☐
Cortisone treatments	☐	☐	Mitral valve prolapse	☐	☐	Tumor or growth on head or neck	☐	☐
Cough, persistent or bloody	☐	☐	Nervous problems	☐	☐	Ulcer	☐	☐
Diabetes	☐	☐	Pacemaker	☐	☐	Venereal disease	☐	☐
Emphysema	☐	☐	Psychiatric care	☐	☐	Weight loss, unexplained	☐	☐

Allergies

Are you allergic to any of the following?

☐Local anesthetics ☐Sulfa drugs ☐Sedatives ☐Iodine ☐Any metals(nickel/mercury) ☐Penicillin or other antibiotics

☐Latex ☐Other- Please describe___________________________________

Medications

Please list all current medications and the correlating diagnosis:____

____

Women Only:

Are you pregnant or think you may be pregnant? **Y N** Are you nursing? **Y N** Are you on birth control? **Y N**

I certify that all of the preceding answers and information provided are true and correct to the best of my knowledge:

____Date______/______/_____

Patient/Representative Signature (Parent/Legal Guardian must sign if patient under 18)

Welcome to Ricard Family Dentistry

Registration **Today's Date ___/____/____**

Name____

If Patient is under 18, Parent/Legal Guardian Name____

Home phone(____)____________________ Alt phone(cell/work) (____)______________________________

Address____ Apt # ___________

City__________________________ State________ Zip Code______________

Patient Date of birth :______ /_______/_______ Sex: □ Female □ Male □ Single □ Married

Soc. Sec #____________________________________ E Mail: __________________________ @_______________

In case of emergency call: Name_________________________________ Phone(____) ___________________________

Relationship to patient: □ Parent □ Guardian □ Friend Other: ______________________

Insurance Info

Do you have insurance? □ Yes □ No

Subscriber Name____

Subscriber Social Security #____Subscriber DOB_____ /_____ / ______

Employer____Phone(_____)_______________________

Name of Insurance Company_____________________________________ Phone(____) ________________________

ID#_____________________________________ Plan Name_____________________ Group #____________________

DENTAL HISTORY

Former Dentist____ Phone(____) ________________________

Date of last dental visit? _____/_____ /_____ Date of last dental x-ray? _____/_____ /_____

How often do you brush?________________________ How often do you floss?__________________

Physician Name____ Phone(____) ____________________________

Date of last visit? _____ /_____ /_____ Pharmacy Name_____________________ Phone(_____)________________

Please check every box if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Food collection between teeth	☐	☐	Orthodontic treatment	☐	☐
Bleeding gums	☐	☐	Mouth pain, brushing	☐	☐	Pain around ear	☐	☐
Blisters on lips or mouth	☐	☐	Grinding teeth	☐	☐	Periodontal treatment	☐	☐
Burning sensation on tongue	☐	☐	Gums swollen or tender	☐	☐	Sensitivity to cold	☐	☐
Chew on one side of mouth	☐	☐	Jaw pain or tiredness	☐	☐	Sensitivity to heat	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Lip or cheek biting	☐	☐	Sensitivity to sweets	☐	☐
Clicking or popping jaw	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitivity when biting	☐	☐
Dry mouth	☐	☐	Mouth breathing	☐	☐	Sores or growths in your mouth	☐	☐

Ricard Family Dentistry
1818 S.E. Port St. Lucie Blvd.
Port St. Lucie, FL 34952

Office Financial Policy

Payment is expected on the day service is provided. We offer a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile.

Regarding Dental Insurance

Our office understands the value of insurance benefits to our patients. Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. *We accept most* dental insurance *plans and we will do all we can to assure you of maximum benefits. Once we confirm your dental coverage we will estimate your deductible and the portion that we feel will be covered by your insurance carrier, you will be asked to pay your estimated part of your bill at the time of your service. We will then file and submit to your insurance at no charge to you. After your insurance pays, any remaining balance will be billed to you. We cannot guarantee what your insurance company will pay,* please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered under the terms of your insurance policy. *However, we* can submit an insurance pre-estimate to your insurance company before any major work is done. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event your insurance company has not paid your account in full within 90 days, the balance may be transferred to your account.

Payment Options

- **Cash/Checks/Debit:** There will be a $35.00 fee for returned checks.
- **Credit Cards:** We accept most major credit cards.
- **Care Credit:** *If you need help paying for procedures your insurance doesn't cover or want convenient monthly payment options with no up-front costs then CareCredit could be the answer for you. CareCredit gives you the freedom to get your procedure whenever you're ready. Upon credit approval we will be able start your treatment plan and you'll be on your way to a healthier smile.* CareCredit *is an outside source of revolving credit. It is similar to a conventional credit card, but its use is restricted to dental and medical services. You can apply for care credit at our office or online, it only takes a few minutes and there is no application fee. Most importantly, Care Credit offers you the opportunity to enjoy the benefits of dental health without the financial strain.*

Missed Appointments

Once an appointment has been made, that time is reserved specifically for you. We reserve the right to charge a $25.00 for all canceled or missed appointments without 48-hours notice.

Duplicate Records

We will be glad to forward your records upon written request that should include the name and address of your chosen dentist. A minimum of 5 working days will be required for this service. Patients requesting their own copy will be charged a $17.00 fee to cover reproduction costs.

Informed Consent for Routine Dental Treatment

In order to provide comfortable dental treatment local anesthesia may be administered. Possible Complications include but are not limited to:

- Local pain/or infection
- Temporary but potentially permanent numbness or altered sensation to the nerve that goes to the lip, tongue, gum, etc…
- Systemic (whole body reaction) including allergic reaction.
- Additionally, pain or prolonged discomfort to the jaw joints. Although usually temporary.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature____ Date: ___________________