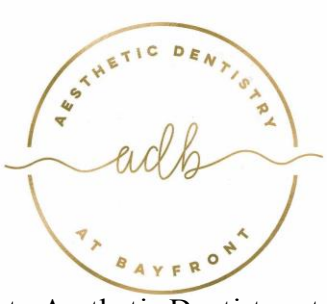


Welcome to Aesthetic Dentistry at Bayfront.

We look forward to providing you with a comfortable dental experience and outstanding results.

*Please fill out the registration and history forms completely. Thank you!*

Name:_____ Date:_____
*(First) (Last) (Preferred Name)*

Primary Address: _____
*City State Zip Code*

Address (Other) _____
*City State Zip Code*

Phone: _____ _____ Ok to leave voicemail? Yes No
*Home Mobile Circle*

Email Address: _____ Ok to text? Yes No
*Circle*

Date of Birth _____Social Security #_____Occupation_____

Who may we thank for referring you to our office?_____

**DENTAL INSURANCE**

Dental Insurance Name: _____ Policy # _____

Address: _____ Phone # _____

Policy Holder Name:_____ Policy Holder DOB:_____

Policy Holder SSN # _____ Relationship: _____

Employer's Name and Address: _____

_____

Do you have any records from a previous office that we may obtain? ☐ Yes ☐ No

Previous Dental Office Name & Phone #: _____

Are you seasonal? If so, what months are you in Naples?_____

## MEDICAL HISTORY

**Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving a blank will indicate a "No" response.**

- ☐ *Pre-Med
- ☐ Artificial Joints
- ☐ Smoker
- ☐ HIV+/AIDS
- ☐ Herpes
- ☐ Parkinson's Disease
- ☐ Vertigo
- ☐ Asthma
- ☐ Hepatitis
- ☐ Blood thinning medication
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Bypass
- ☐ Pacemaker
- ☐ Artificial Valve
- ☐ Atrial Fibrillation
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Tumors
- ☐ Cancer/Chemo
- ☐ Radiation Treatment
- ☐ Alzheimer's Disease
- ☐ Liver Disease
- ☐ Kidney Disorder
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Thyroid disorder
- ☐ Diabetes

***Allergies:**

- ☐ Latex
- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Tetracycline
- ☐ Clindamycin
- ☐ Codeine
- ☐ Other Antibiotics/Medications

*List of medications (prescription and non-prescription)

_____

*Please list the name of your Pharmacy, location and phone number:

_____

*Please list the name, location and phone number of Physician:

_____

*Are you satisfied with the appearance of your teeth?

_____

*Are you interested in improving the appearance of your teeth?

_____

## Financial & Dental Insurance Policy

Please note that you will be responsible for payment at the time of service.

For those patients who have dental insurance, we are happy to submit your insurance claims with the carrier information you supply us with. We understand that insurance can be a helpful supplement toward your dental treatment, so be assured that we will use all necessary resources to ensure that you receive maximum benefit under your specific plan. However, you are responsible for all charges whether paid by insurance or not at the time of service.

☐ I have read the above conditions of treatment and payment and agree to their consent.

## Aesthetic Dentistry at Bayfront Notice of Privacy/Consent Form HIPPA

Our notice of privacy practices provides information about how we may use and disclose "Protected Health Information" or "PHI" about you. You have the right to review our notice before signing, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the office.

By signing this form you consent to our use and disclosure or protected health information. You have the right to revoke your consent, in writing signed by you. However, such a revocation shall not affect any disclosure we may already have made in reliance on your prior consent. Our practice provides this form to comply with the Health Insurance and Accountability Act of 1996. (HIPPA)

The patient understands that:

1. Information may be disclosed to other providers who may be involved in your continuing care and course of treatment directly or indirectly.
2. Information may be disclosed to obtain reimbursement from your insurance company that we have on file for payment.
3. Information may be disclosed for all billing and collection activities.
4. Information may be disclosed for the authorization of any prescriptions to the pharmacy on your behalf.

Do we have permission to talk to any of your family members regarding Appointments, Billing, & Treatment? ☐ Yes ☐ No If yes, please provide name and phone number below.

_____

Signature: _____ Date: _____

# NO SHOW/CANCELLATION POLICY

We schedule our appointments so that each patient receives the right amount of time to be seen by our dentists and staff. It is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy to help patients remember their scheduled appointments, we send a text message or call a few days prior with a reminder.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule your appointment and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as those patients who are waiting to schedule with the dentist, please give us at least 48 hours' notice.

***If you cancel or reschedule with less than 24 hours' notice, a charge of $100 will be applied to your account.***

***If you "no show" to a scheduled appointment we will require payment in full upfront when rescheduling.***

☐ I have read the above conditions and policies and agree to their consent.

Signature: _____ Date: _____