Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

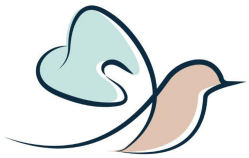
Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____

Signature _____ Date _____



Sandpiper Dental

Kim Doan D.M.D
13947 Beach Blvd Ste 106
Jacksonville, FL 32224
Phone : 904-223-8001
Fax : 904-223-8022

TO ALL PATIENTS

A parent or guardian must be present for a child's examination by the doctor. Payment is due at the time service is rendered, unless other arrangements have been approved in advance of your visit. We accept cash, checks, MasterCard, Visa, Discover, American Express and Care Credit.

Your appointment is time we reserve just for you. We really count on you being here. If you are unable to keep your appointment, we ask that you give us the courtesy of 48 hours notice. This will allow us to schedule other patients who are waiting for necessary treatment. In the event you fail two or more appointments without a minimum 48hr notice, a $75.00/hour missed appointment fee will be charged. We appreciate your cooperation.

AGREEMENT REGARDING YOU & INSURANCE COVERAGE

This statement will avoid any misunderstandings commonly found when working with insurance. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies. We will be happy to help you process your insurance claim; however, any deductible andlor percentage not covered by your insurance policy is due at the time of service.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract
2. Our fees are based on the quality of service provided, and generally fall within the "UCR Standards" set by most insurance companies. "UCR Standards" are defined by your insurance company as Usual, Customary and Reasonable fees for this region.
3. Not all services rendered are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that as a dental provider of care, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges at your responsibility from the date selice is rendered.

If you have any questions about the above policies, or any uncertainty regarding your insurance coverage, please don't hesitate to ask.

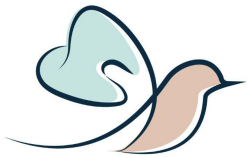
FINANCIAL AGREEMENT

I understand the above policies and agree that I am responsible for the payment of all treatment fees oil my account. I understand that payment is due at time of service & failure to pay balance due will incur a 50% collection cost of the unpaid debt.

AII Patients - Please Sign Below

Signed:_____

Date:_____



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Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with

_____

and assign directly to Dr. Kim Doan 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 the use of my signature on all insurance submissions.

The above named dentist may use my health/dental care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current insurance coverage is terminated.

_____ _____

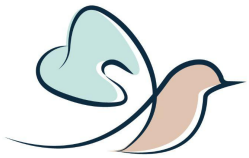
Signature of Patient or Guardian Date

_____ _____

Print name of Patient or Guardian Date

Changes to Insurance

_____	_____	_____
Insurance Co	Date	Initial
_____	_____	_____
Insurance Co	Date	Initial
_____	_____	_____
Insurance Co	Date	Initial



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/ar disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices

_____

Please print your name here

_____ _____

Signature Date

CONFIDENTIALITY

The office of Dr. Kim Doan & her employees are bound by Florida Statute 395.01.7 which provides that patient medical records are privileged and confidential and may not be disclosed without the consent of the patient. No patient information shall be given to anyone telephoning or inquiring about a patient or former patient, including spouses, family members, relatives, employers, former patients, unless a valid patient consent has been obtained.

_____ No, I do not consent to release the information in my medical record

_____ Yes, I hereby consent to release any and all information from my medical record to

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____