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4512 North Flagler Drive, Suite 301
West Palm Beach, FL 33407

Name _____

Birth date _____ Age _____ Sex _____ Marital Status _____

Address _____ City/State/Zip _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-mail _____

Patient Employed By _____

Business Address _____ City _____

Occupation _____

Name of Spouse / Parent _____

Social Security # _____ S.S. # Spouse/Parent _____

Name of Dental Insurance Company _____

Patient Referred By _____

So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to definite arrangements of appointments and fees. Once you have made your appointment, remember that this time is reserved for you – Therefore, AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE THE USUAL FEE CHARGE WILL BE MADE. Also, there will be an 18% finance charge on all unpaid balances over 30 days.

Date: _____

I accept responsibility:

Signature

Reviewed By: _____

DENTAL HEALTH HISTORY

Confidential

Today's Date _____

Patient Name _____ Birthdate _____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) Yes No

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List medications you are currently taking: _____

Pharmacy Name _____

Phone _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex _____ |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

FINANCIAL ARRANGEMENTS & INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered by our staff. We accept cash, checks, MasterCard, Visa, Discover & American Express. You may wish to ask about our bank financing program. We will be happy to help you process your insurance claims for reimbursement. Any such request must be accompanied by all of the necessary information.

Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges of 18% per month. Charges will also be made for broken appointments cancelled without 24 hours notice.

Regarding Insurance:

1. Your insurance is a contract between you, your employer & the insurance company. We are not a party of that contract.
2. You MAY have a policy which pays a percentage (such as 50%, 80% or 100%) of "UCR". UCR is defined as usual, customary & reasonable fees for this region. Our fees are generally considered to fall within the accepted by most insurance companies. This statement does not apply to companies who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard of cost & care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies select certain services that they will not cover.

PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS

I understand that if my insurance carrier has not paid within 60 days, the full balance becomes my responsibility. Initial_____

Any disputes between you and your carrier over coverage are between the two of you and does not involve our practice. However, we will supply you with duplicate invoices should you need them. Initial_____

Signature of Patient/Guardian

Date

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or healthcare options. I also understand you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____

Signature: _____

Relationship to patient: _____

Date: _____