Welcome to Gulf Cove Dental!

Thank you for choosing our practice as your preferred dental care provider. We look forward to getting to know you and working to establish a long and trusted relationship together!

To get to know us a bit better before your first appointment we have included our practice's philosophy, promise and commitment below.

Our Philosophy:

Our goal at Gulf Cove Dental is to help each and every one of our patients have healthy teeth and gums for a lifetime. We strive to provide the very best that dentistry has to offer. To us, dentistry is more than just filling cavities and cleaning teeth, it is about helping you feel good, feel confident and enjoy your smile for the rest of your life.

Our Promise to You:

As a new patient at our practice, you can expect to receive the highest quality dental care possible close to home, in a relaxed and friendly environment. From your first call to our office, to your visit with one of our dentists, each step of the way you will be treated with care and respect. We will listen to your concerns, take the time to answer your questions and propose the best treatment based on your needs and circumstances so you can have healthy teeth and gums for a lifetime.

Our Commitment to Excellence:

Our doctors are committed to providing excellent care and maintaining the highest ethical, personal and professional standards possible. We continually advance our knowledge in dentistry through education so we are able to provide you with the best dentistry has to offer.

Welcome to our practice, we look forward to seeing you soon!

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Spouses Name:

Childs Nam:

Pharm. Number:

Emergency Number:

Care Credit #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

PATIENT NAME _____ **DOB** _____

DENTAL HISTORY

Please describe your chief oral complaint: _____
_____

Date of Last Exam: _____ Date of Last Hygiene: _____

Do you have a history of Periodontal Disease ( ) Yes ( ) No

Do you require antibiotics prior to dental treatment ( ) Yes ( ) No
Are your teeth sensitive to hot or cold ( ) Yes ( ) No
Would you like to keep your natural teeth ( ) Yes ( ) No
Do your gums ever feel tender or swollen ( ) Yes ( ) No
Do your gums bleed when brushing ( ) Yes ( ) No
Do you clench or grind your teeth ( ) Yes ( ) No
How many times a day do you brush_____ Floss_____

Have you ever had a serious/difficult problem associated with any previous dental work?

( ) Yes ( ) No If yes, please explain _____

_____

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) ( ) Yes ( ) No
Do you like the appearance of your smile? ( ) Yes ( ) No
What would you do to improve your teeth or smile? _____
_____

STATEMENT OF ACCURACY:

To the best of my knowledge the above information is accurate and correct.

_____
Signature of Patient and/or Legal Guardian

PAYMENT POLICY

At Gulf Cove Dental, Dr.Feit and our team members are committed to providing high quality dental care at competitive fees. In order to keep the costs of your care competitive, we require prompt payment for all services rendered. The following paragraphs outline our financial policy.

For routine appointments such as cleanings, exams, or any dental work requiring an appointment less than 90 minutes, your complete payment is due on the day of service.

For services that require appointments of 90 minutes or more, we require complete payment before the appointment is scheduled.

For your convenience, we offer several payment options to our patients. We will accept cash, check, Visa and Master Card. If you require financing, we offer the following options:

- Interest free payment plans are available thru Care Credit for 6 or 12 months depending on the procedure amount
- Extended payment plans for up to 60 months or greater are also available thru CareCredit with incurred interest.

At Gulf Cove Dental, we are a fee for service office.

What does this mean for you as a patient?

- We file your insurance claim
- Instead of the insurance company paying us, they will pay you

Past due accounts will be charged 3.5% interest for every month they are overdue.

We request your signature below affirming that you understand and agree to the financial policies of Gulf Cove Dental.

_____ _____/_____/_____

Signature of Patient or Account Guarantor Date

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Patient Name: _____Date:_____

1.HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

2.PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes spouse, step parents, and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____

Name: _____ Relationship: _____

3.I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA (please choose all that may apply):

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

4.I AUTHORIZE MY CONSENT OF MY MINOR CHILD OR CHILDREN:_____

SIGNATURE OF PARENT/GUARDIAN:_____

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because

Other (please describe):
Signature of Privacy Officer_____

Gulf Cove DENTAL

Medical History

Patient Name: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions. Please check yes or no.

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*Are you under a physician's care now? YES ◯ NO ◯

If yes_____

*Have you ever been hospitalized or had a major operation? YES ◯ NO ◯

If yes_____

*Have you ever had a serious head or neck injury? YES ◯ NO ◯

If yes_____

*Are you taking any medications, pills, or drugs? YES ◯ NO ◯

If yes_____

*Do you take or have you taken, Phen-Fen or Redux? YES ◯ NO ◯

If yes_____

*Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? YES ◯ NO ◯

If yes_____

*Are you on a special diet? YES ◯ NO ◯

If yes_____

*Do you use Tobacco? YES ◯ NO ◯

If yes_____

Do you used controlled substances? YES ◯ NO ◯

If yes_____

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic

◯ Metal ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics

Other:_____

Gulf Cove DENTAL

Do you have any, or have had any of the follow? Please check (Y) yes or (N)no.

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

Have you ever had any serious illness not listed above? YES ◯ NO ◯

If yes_____

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Signature below of Patient, Parent or Guardian

X_____ Date:_____