CONSENT:

I understand that this examination is going to address my immediate problem or emergency and should not be confirmed as a complete examination with resulting treatment.

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

PATIENT NUMBER

EMERGENCY RECORD

PATIENT'S NAME _____
Last First Initial

IF CHILD:
PARENT'S NAME _____
Last First Initial

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE: RES. _____ BUS. _____

CELL _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

DRIVER'S LICENSE NO. _____

METHOD OF PAYMENT: Insurance ☐ Credit Card ☐ Cash ☐

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

NAME AND TEL. NO. OF SOMEONE NOT LIVING WITH YOU TO NOTIFY IN CASE OF EMERGENCY _____

_____

Date _____ Date of Birth _____

DENTAL INSURANCE - 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

DENTAL INSURANCE - 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

NAME OF INSURANCE COMPANY _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

PATIENT'S NAME _____

REFERRED TO DENTIST BY _____

MEDICAL INFORMATION

Name Of Your Physician _____ Last Physical _____

Are You Taking Any Medications? _____ Please List _____

Are You Allergic To Any Medications/Food/Latex? _____ Please List _____

Have You Been Hospitalized In The Last Five Years? _____ Why? _____

DENTAL INFORMATION

How Long Has It Been Since Your Last Dental Visit? _____

What Was Done At That Time? _____

What Is Your Problem or Complaint At This Time? _____

How Long Has It Been A Problem? _____

Do You Have, Or Have You Ever Had?	Please Circle	
Heart Murmur	YES	NO
Fainting Spells	YES	NO
Heart Condition	YES	NO
Malignancy	YES	NO
Abnormal Blood Pressure	YES	NO
Tuberculosis	YES	NO
Abnormal Bleeding	YES	NO
Positive HIV Test	YES	NO
Anemia	YES	NO
Radiation Therapy	YES	NO
Diabetes	YES	NO
Venereal Disease	YES	NO
Epilepsy/Seizure	YES	NO
Hepatitis	YES	NO
Stomach, kidney or liver problems?	YES	NO
Asthma	YES	NO
Rheumatic Fever	YES	NO
Artificial joint, prosthesis	YES	NO
Might You Be Pregnant?	YES	NO
Do you have any other medical conditions?	YES	NO

Comments _____

ANEST.

PROGRESS NOTES

MED. ALERT

DATE	TOOTH #	TREATMENT	PROCEDURE CODE	DR. / ASST./HYG.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

_____ attempted to obtain patient's acknowledgement but was unable to do so. The reason it was not obtained was _____

Signature _____

Date _____

Adult Dentistry Of SWFL

Dr.Norma Jeanne Appelbaum
1519 SE 47th Terr, Cape Coral
(239) 549-6100

Health care costs must be controlled, we all agree. For that reason I charge reasonable and comparable fees for my services. However my billing lab fees and insurance filling fees have risen and continue to rise constantly. For that reason, rather than be forced to raise fees, I chose to reduce my costs by collecting fees at the time service is rendered. Therefore, payment is expected at the time of service.

For your convenience, I accept cash/debit cards, checks, Visa/MC, Discover, American Express. For those who require financing we work with Care Credit.

Your insurance may reimburse you for services rendered through this office but you must understand that my professional relationship is with you and not your insurance company. You are responsible, not the insurance company, for paying for my services. Because I=insurance payments are uncertain and slow, I cannot accept the promise of insurance coverage instead of payment. Since I cannot possibly know the provisions of each patients insurance policy, it is your responsibility to meet the requirements and limitations of your insurance coverage. I feel that if this is all understood, it will not become a financial stressor to our relationship later on.

ALL CROWN AND BRIDGE, REMOVABLE PARTIALS OR DENTURES MUST BE PAID FOR PRIOR TO DELIVERY

For appointments of 2 hours or more a NON REFUNDABLE $500 deposit will be made to guarantee the time, this will be put toward the services done at that appointment unless the appointment is cancelled without 2 working days prior notice.

I have read and understand this policy and agree to abide by it_____(initial)

I will be paying with _____cash _____ credit/debit card _____check

_____ _____

Signature Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

_____ attempted to obtain patient's acknowledgement but was unable to do so. The reason it was not obtained was _____

Signature _____

Date _____