817 Westport Drive
Rockledge, FL 32955
321-433-1141

Dear Patient:

Our billing department is asking for a credit card number and expiration date on which any outstanding balances will be billed or **credits refunded**.

You will only be charged the portion of the insurer determined amount not paid by the insurer for the services provided which they determine to be your share of cost and is not to exceed $200.00, unless approved by you. In the past you would have received a statement requesting your share of cost.

This policy will be no different than what most businesses such as hotels and airlines already implement. This information will be confidential and protected just as your medical record is.

As with any other transaction, as a cardholder you have the right to challenge any charges against your account.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely,

Ocean Breeze Dental

I authorize Ocean Breeze Dental to charge outstanding patient portion balances for my dependents and I to the following credit card:

(Please circle one) Visa Mastercard American Express Discover

Account number: _____

Expiration date: _____ Signature code: _____ Billing zip code:_____

Full name on card (please print):_____

Signature:_____

OCEAN BREEZE DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

MEDICAL HISTORY

PATIENT NAME _____ Birth 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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

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 OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Regarding Financial Arrangements And Your Dental 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 understanding of our financial policy.

Payment for services is due at the time services are rendered. We accept cash, check, MasterCard, Visa, American Express, and Discover. We file insurance and we will be happy to process your insurance claim for you. We are also proud to offer CareCredit as an interest-free financing option.

Returned checks and balances older than 30 days may be subject to additional collection fees, interest, or finance charges monthly.

Please keep in mind that scheduled appointments are times reserved just for you. As the patient, you are responsible for keeping your scheduled appointment. However, as a courtesy, we will try to telephone you to confirm your appointment. Failed appointments or those cancelled with less than 24 hours notice will be subject to a cancellation fee of no less than $35.

In regards to your insurance:

1. Your insurance is a contract between you, your employer, and the insurance company. We **are not** a party to that contract.
2. Insurance will cover a percentage of what they consider "usual and customary," *not of what we charge.* **If the insurance payment has not been received within sixty (60) days of the billed service the patient will be billed for and is expected to pay the total balance due.**
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. **We plan dental treatment based on what is best for you, our patient, not on what your insurance will provide benefits for.** Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee out-of-pocket cost due to the complexities of insurance contracts. Please refer to your insurance handbook or call them for the specific details regarding allowable services, percentages at which services are covered, and any other specific details.
4. We would like to make it clear that this is a **mercury and amalgam-free free office**. *We do not, nor will we ever, place amalgam (silver-colored) fillings in your mouth*. If that is all your insurance will pay for there will be a balance remaining on your account once we receive payment back from them that you will be expected to pay. If this is an issue to you, **please make it clear to the doctor before any work is started**.
5. If out-of-pocket expense is of major concern for you, please be sure to request that a pre-determination be sent to your insurance company. We do not automatically send them and any prices quoted in our office to patients with insurance are simply estimates. Pre-determinations take approximately one month to be returned, but we are always happy to start your treatment without them.

We must emphasize that, as your Dental care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, it is not our responsibility to know every detail regarding your insurance plan. We are more than happy to answer any questions about your account to the best of our ability on the occasion that you do not understand something.

If you have any questions about the above information, PLEASE don't hesitate to ask. We are here to help you.

I understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered. I have read the information above and understand.

Signature _____ Date_____