BOCA DENTAL ARTS

Where Art & Dentistry Meet

Patient's name: Date of birth:

Mailing address: Zip:

Telephone: Email:

Dental Information

Please check if:	yes	no
your gums bleed when you brush or floss		
your teeth are sensitive to cold, hot, sweet, or pressure		
you have had periodontal (gum) treatment		
your mouth is dry		
you wear partials or dentures		

Please check if:	yes	no
you have ear aches or neck pains		
you have clicking, popping, discomfort in the jaw		
you brux or grind your teeth		
you have sores or ulcers in your mouth		
you had any problems associated with previous dental treatment		

The reason for your visit today? How did you hear about our office?

Please check if you are allergic to / reaction to:	**yes**	**no**
local anesthetic ("Novocain")		
penicillin or other antibiotics		
barbiturates, sedatives, sleeping pills		
sulfa drugs		
codeine or other narcotics		
metals		

Please check if you are allergic to / reaction to:	**yes**	**no**
latex (rubber)		
iodine		
animals		
food		
hay fever /seasonal		
other		

Please check if require Pre-Medication:	**yes**	**no**
artificial (prosthetic) heart valve / joint		
previous infective endocarditis		

Medical History Information

Check if in present or past you have had:	yes	no
Allergies, Hay Fever		
Anemia		
Arthritis, Rheumatism		
Artificial heart valve		
Artificial joints		
Asthma		
Asthma, with Steroids		
Bleeding abnormally with surgery		
Blood disease, clotting disorders		
Cancer		
Chemotherapy, Radiation		
Circulatory problems		
Congenital heart defect		
Cortisone treatment		
Diabetes (Type:)		
Eating disorder		
Emphysema		
Epilepsy		
Fainting		
Gastrointestinal disease/Reflux/Heartburn		
Glaucoma		
Headaches		
Heart murmur		
Heart attack/Heart problems		
Heart valve damage		
Hepatitis (Type:)		
Herpes		

Check if in present or past you have had:	yes	no
Hemophilia		
High blood pressure		
Low blood pressure		
Immune deficiency (HIV/AIDS)		
Kidney disease		
Mental health disorders		
Mitral valve prolapses		
Osteoporosis		
Pacemaker		
Respiratory disease		
Scarlet fever		
Sexually transmitted disease		
Shortness of breath		
Sinus trouble		
Sickle cell anemia		
Skin rash		
Stroke		
Thyroid problems		
Tonsillitis		
Tuberculosis		
Tumor or growths on head/neck		
Ulcer		
Cigarettes, pipe, cigars, vaping		
Smokeless tobacco		
Alcoholic beverages		
Controlled substances		
Currently Pregnant, Nursing		

Please list all prescription and over the counter medications, including vitamins, herbal preparations, and supplements:

_____

_____

Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment. You certify that you have read and understand the above and that the information given on this form is accurate. You understand the importance of a truthful Heath History and that Dr. McGuffie and his staff will rely on this information for treating you. You acknowledge that your questions, if any, about inquires set forth above have been answered to your satisfaction. You will not hold Boca Dental Arts PA, Dr. McGuffie, or any member of the staff, responsible for any action they take or do not take because of errors or omissions that you may have made in the completion of this form.

Patient/Guardian's Signature: _____ Date: _____

Health Insurance Portability and Accountability Act (HIPAA)

You understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your protected health information. The Notice of Privacy Practices provides information about how we may use or disclose your protected health information. You may contact us at any time to obtain a current copy of the Notice of Privacy Practice.

- You acknowledge that our Notice of Privacy Practices, containing a complete description of the uses and disclosers of your protected health information, has been made available to you and that you have been given the opportunity to ask question about the Notice of Privacy Practice. You may request in writing that we restrict how your private information is to be used or disclosed. However, such a restriction will not be retroactive.

- You authorize this office to release medical information to insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits.

- You consent to allow us to contact you and leave messages (by phone or email) to remind you of an appointment or provide you with information about treatment or other health-related services.

- You give this office permission to discuss your healthcare with the following people (if none write NONE):

  Name:_____ Relationship:_____

  Name:_____ Relationship:_____

You hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to you. You have been given the opportunity to ask any questions you may have regarding this Notice.

Print Patient's Name:_____

Patient/Guardian's Signature:_____ Date:_____

Financial Policy and Missed Appointments

Financial Policy

Payment is due in full on the day of your treatment. For procedures requiring multiple appointments, half payment may be collected at your initial appointment and any remaining balance will be collected at your final appointment.

If you are using dental insurance, please note that your insurance policy is an agreement between you and your insurance company. We are a third party. You are responsible to know your insurance policy, its benefits and requirements. We do not determine the amount of coverage you will receive, your insurance company does that.

Missed Appointments

Boca Dental Arts is committed to providing you with exceptional, dedicated care. We are working extra hours post COVID-19 closure and pride ourselves in providing extra time for the personal attention each patient deserves. As a result, your appointment time is highly valued and is reserved exclusively for you.

In order to be respectful of the needs of our patients, if it becomes necessary for you to change or cancel your reserved time, you may do so within a 24 HOURS WORK DAY to avoid a missed appointment charge.

_____ Failure to do so will be considered a missed appointment and subject to a $90 appointment cancellation charge.

Appointments are in very high demand and your early cancellation will give another person access to dental care. Similarly, if you arrive 10 minutes past your appointed time, it may need to be rescheduled and considered a missed appointment as it affects our ability to provide timely attention to our other patients.

We appreciate your kind understanding and respect for all of our patients.

Patient/Guardian's Signature:_____ Date:_____

What you Should Know If You Are Using Dental Insurance…

Dental insurance is one form of payment toward your treatment needs. Your insurance is a contract between you, your employer or plan sponsor, and the insurance company. We are not a party to that contract. These contracts vary widely from patient to patient. We will do our best to estimate the portion your insurance company will pay with the information that we have. We cannot guarantee payment from your insurance company and your balance may be different than our estimate. In the event that your insurance company refuses to pay all or a portion of your claim, you are ultimately responsible for payment for those charges.

You should know that insurance companies cover very few procedures in full. You should understand which procedures your plan will reimburse and at what percentages. There may be an annual deductible that your insurance company requires dentists to collect. There may also be a co-pay for your procedures. Your insurance company sets a maximum limit to the amount of work they will pay. Even if you use up your maximum dental benefits, you are still responsible to pay your balance for that treatment.

By assigning payment for your dental treatment from your insurance company to this office:

1. You agree that the charges you incur are your responsibility regardless of what your insurance company pays or does not pay toward your treatment.

2. You agree to pay your bill in full if your insurance company has not paid within 30 days.

3. You understand that we are not responsible for knowing the various scenarios in which your insurance does or does not pay for services. The estimate of coverage presented to you is not a guarantee of eligibility, as policy provisions, such as pre-existing conditions, waiting period, x-rays restrictions, less costly alternative, pre-authorizations, replacement frequency, missing tooth clauses, possible charges from other offices, etc., can affect payment. We try to provide you with as much information as possible, however, we cannot be responsible for knowing the various intricacies of your particular insurance contract.

4. Certain procedures, although necessary for your care, might not be covered by your insurance company. Sometimes, insurance companies will arbitrarily "down-code" a procedure. The limitations set by your insurance company should not be looked at as a reason not to choose treatment. You agree that you will be billed for the difference in cost if your insurance company replaces your benefit with this less costly "down-coded" alternative.

5. You assign directly to us all insurance benefits otherwise payable to you for services rendered. You authorize the use of your signature on all insurance submissions. We may use your health care information and may disclose such information to your insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits.

Patient/Guardian's Signature:_____ Date:_____