Merritt Island Smiles

Welcome to Dr. Anthony Sidor's Office

Thank you for selecting our dental healthcare team. In order for us to provide you with the best possible dental care, please fill out this form completely. If you have any questions or need assistance please ask us – we will be happy to help.

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Whom may we thank for referring you? _____

Patient Information

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: ____ Cellular: _____

Sex: ○ Male ○ Female Martial Status: ○ Married ○ Single ○ Divored ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ○ I would like to receive correspondences via e-mail

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____

City, State, Zip: _____

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

E-mail: _____ ○ I would like to receive correspondences via e-mail

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Emerg Contact Name: _____

Emerg Contact #: _____

Pharmacy Name: _____

Pharmacy #: _____

Physician Name: _____

Physician's #: _____

Primary Insurance Information

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Name of Insured: _____ Insured Birth Date: _____

Group Number: _____ Ins. Company: _____

Insured Soc. Sec: _____ Address: _____

Insured Member ID#: _____ Address 2: _____

Employer: _____ City, State, Zip: _____

REGARDING INSURANCE

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ESTIMATED FEE FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS, WITHIN 30 DAYS OF STATEMENT.

PATIENT MEDICAL HISTORY

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 list below:**

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No **If yes, please circle medication**

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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

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

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

List Medications:

Date: _____

Medication Name: _____ Dosage: _____ Usage: _____

Medication Name: _____ Dosage: _____ Usage: _____

Medication Name: _____ Dosage: _____ Usage: _____

Medication Name: _____ Dosage: _____ Usage: _____

Medication Name: _____ Dosage: _____ Usage: _____

Medication Name: _____ Dosage: _____ Usage: _____

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 responsability to inform the dental office of any changes in medical status.

UPON UPDATING YOUR PATIENT INFORMATION AND MEDICAL HISTORY, PLEASE RETURN TO THE DESK SO THAT WE MAY MAKE THE NECESSARY CHANGES AND OBTAIN YOUR SIGNATURE.
THANK YOU

Merritt Island Smiles
Anthony J. Sidor DDS

New Patient Questionnaire

This questionnaire will help us better understand your dental history and will assist us with any concerns you may have for your future dental treatment.

Dental History

Why are you changing dentists? _____

Do you have any current dental concerns with your mouth?	Yes	No
Explain: _____		
_____		
Have you ever had a local anesthetic (Novocaine, etc.)?	Yes	No
Have you ever had an adverse reaction to a local anesthetic?	Yes	No
Have you ever had any problems associated with previous dental treatment?	Yes	No
Have you had any injuries or surgeries to your face, mouth, or teeth?	Yes	No

If yes, explain_____

Oral Hygiene/Habits

Have you ever had red, bleeding, or swollen gums?	Yes	No
If yes, When _____? How long? _____		
Have you ever been told you have gum disease?	Yes	No
If yes, what treatment was done? _____		
How often do you get your teeth cleaned? _____		
Do you currently use an electric toothbrush?	Yes	No
Do you experienced dry mouth?	Yes	No
Do you notice that you mouth breathe when you are awake and/or asleep?	Yes	No

Treatment History

Do you have any pain, popping, clicking, or locking on opening or closing your mouth/jaw?		Yes	No
Have you ever had orthodontic treatment (braces)?		Yes	No
Do you have a splint, mouth guard, or night guard?		Yes	No
If yes, is the material	(circle type)	Soft	Hard
Do you have an Upper Denture or Partial?		Yes	No
Do you have a Lower Denture or Partial?		Yes	No
Are you happy with the appearance, feel, function and color of your teeth?		Yes	No

If no, explain_____

If you could change your teeth in anyway, what would you change?

_____

_____

Anthony J. Sidor, D.D.S.
225 S. Plumosa Street – Merritt Island, FL 32952
Ph: (321) 453-1890 - Fax: (321-453-1521

PAYMENT AGREEMENT

PLEASE KEEP THIS AGREEMENT FOR YOUR RECORDS

All fees are due when services are rendered. Payment options are limited as follows:

INSURED PATIENTS:

As a courtesy to our patients, we file to most dental insurances and will accept payment. Sometimes there is a difference between our fee and what your dental insurance will pay for a service. Since we are not in network with **ANY DENTAL INSURANCES,** please keep in mind you are ultimately responsible for all services rendered and any balance after your insurance pays.

We will be happy to estimate and file your primary insurance. Payment of your deductible and portion of the fee is due when services are performed. If a treatment requires more than one visit, one half of the patient's portion will be due when treatment is started, the other half will be due when treatment is complete.

PATIENTS WITHOUT INSURANCE BENEFITS:

Three payment options are available:

1. Payment in full prior to treatment: For any treatment over $400 a 5% discount will be given for a cash or check payment of the full amount due for proposed treatment **prior** to the treatment being completed.
2. One half of the total amount due is to be paid when treatment has begun with the other one half due when treatment is completed. (If the treatment is completed in one visit, the total fee for the treatment completed is due at that time).
3. Payment is due in full at the time of service through a third party financing/credit company that will assist in financing your treatment. Information and applications are available from the front office staff.

All accounts past due (over 90 days) are submitted to our Collection Agency.
Any checks returned for non-sufficient funds will be subjected to a service fee. Any discounts applied to payment will be revoked and we will not be able to accept checks as a form of payment moving forward.
We reserve the right to charge a $50.00 late cancellation or missed appointment fee. Our office requires a 24 hour notice.

WE ARE UNABLE TO ACCEPT PARTIAL PAYMENTS

Please be aware, it is not easy for an office to be familiar with the details of every insurance plan it encounters. It is the responsibility of the patient, not the dental office, to know what is covered and what is excluded from his or her dental plan. We expect your deductible and estimated portion due on the day treatment is rendered. *If for any reason, your insurance company does not cover treatment rendered, the balance is your responsibility.*

I HAVE READ, UNDERSTAND AND AGREE TO BE RESPONSIBLE FOR ALL CHARGES THAT I INCUR DURING MY TREATMENT

SIGNATURE WILL BE ACQUIRED ON YOUR FIRST VISIT TO OUR OFFICE.

WE GLADLY ACCEPT VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS

Patient or Responsible Party Signature: _____ **Date:** _____

Merritt Island Smiles
Anthony J. Sidor DDS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgment form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient Legal Relationship to the Patient *(if required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

Name: _____ Relationship:_____ Phone #:_____

Name: _____ Relationship:_____ Phone #:_____

_____ I wish not to share my dental/account information with anyone. *(Initial if you decline)*

Consent to email or text for appointments reminders and other healthcare communication.
We may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to opt out of electronic communication.

Please check your preferred communication:
The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____.
The email address that I authorize to receive email messages for appointment reminders and general health information is _____.
OR
_____ I decline to receive communication via cell phone
_____ I decline to receive communication via email

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICESTHIS FORM DOES NOT CONSTITUTE LEGAL ADVICE AND COVERS ONLY FEDERAL, NOT STATE LAW.