Dr. Patrick DelFlore, D.D.S.

Patient Information

Patient's First Name: _____ MI: ____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: _____ Birth Date: ___/___/____ SSN: _____ Email: _____

Patient's Marital Status: __Married __Divorced __Separated __Single __Widowed

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip:_____

Patient's School: _____

Please Circle One: Part Time Full Time Not a Student

Driver's License Number: _____ State: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear of us? _____

Responsible Party

Person Responsible for Payment of Account if Other Than Patient

Full Name: _____Relationship to Patient: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance

In order to process your insurance claim, we must have a copy of your current insurance card.

All the following information must be provided to file the claim.

Name of Insured/Policy Holder: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insured's Relationship to Patient: Self Spouse Parent Step-Parent Other: _____

Policy Holder Date of Birth: ___/___/___ Policy Holder's SSN: _____

Name of Insurance Company: _____ Phone #: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Policy #: _____ Group #: _____

Policy Holder's Employer: _____ Employer Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

By signing below, responsible party acknowledges the above information is correct and agrees to notify Dr. DelFlore as changes may occur. Responsible party also agrees to pay any deductible, co-pay, co-insurance, or other amounts not covered by insurance. The signature below serves as a "signature on file" authorizing Dr. Patrick DelFlore to release any dental records as required by law for appropriate care with other provides, to process any insurance claims, and to receive payment/insurance benefits otherwise payable to insured. Should responsible party not pay his/her portion as stipulated above, the responsible party shall be liable for payment of any late charges or collection fees that may result. **MISSED OR BROKEN APPOINTMENTS waste valuable manpower and raise fees for everyone. In an effort to reduce this expensive waste, we CHARGE for all broken appointments. A charge of $50.00 will be assessed to you and will need to be paid before your next scheduled appointment. A 48 hour notice is needed to be given to the office to avoid this fee. We adhere to this policy, so please take time to carefully select your appointment time. A 48 hours notice must be within our normal business hours of Monday through Friday, 9am-5pm.**

Signature: _____ Date: _____

Dr. Patrick DelFlore, D.D.S.
Medical/Dental History

Dental History:

Reason for today's visit: _____ Date of last dental visit: _____
Date of last dental x-rays: _____ Former Dentist: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____

Please mark (x) if you have had any of the following:

___ Bad Breath
___ Grinding Teeth
___ Sensitivity to Hot/Cold
___ Bleeding Gums
___ Loose Teeth
___ Sensitivity to Sweets
___ Clicking or Popping Jaw
___ Broken Teeth
___ Sensitivity when Biting
___ Periodontal Treatment
___ Sores/Growth in Mouth
___ Orthodontic Treatment
___ Implant Treatment
___ TMJ Treatment
___ Food collection between teeth

How often do you floss? _____ How often do you brush? _____

Medical History:

Primary Care Physician: _____ Date of Last Checkup: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____

Please mark (x) if you have any of the following:

___ Anemia
___ Arthritis
___ Artificial Heart Valve
___ Artificial Joints
___ Asthma
___ Back Problems
___ Blood Disease
___ Cancer
___ Chemical Dependency
___ Chemotherapy
___ Circulatory Problems
___ Cortisone Treatment
___ Cough, Persistent
___ Cough Up Blood
___ Diabetes
___ Epilepsy
___ Fainting
___ Glaucoma
___ Headaches
___ Heart Murmur
___ Heart Problems
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ HIV/AIDS
___ Jaw Pain
___ Kidney Disease
___ Liver Disease
___ Mitral Valve Prolapse
___ Osteoporosis
___ Pacemaker
___ Radiation Treatment
___ Respiratory Disease
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of Breath
___ Skin Rash
___ Stroke
___ Swelling of Feet
___ Thyroid Problem
___ Tobacco Habit
___ Tonsillitis
___ Tuberculosis
___ Ulcer

Medication: Please list medications and dosages you are currently taking:

_____
_____
_____

Allergies: Please list any allergies or advance reactions you have had:

Medication or Substance:	What kind of reaction did you have?	When did this first occur?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that the above medical/dental information is correct.

Signature: _____ Date: _____

Patrick DelFlore, D.D.S.

Financial Policy

Welcome to our office. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We feel part of providing complete, comprehensive dental services includes treatment and financial information.

Before dental treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees, and allow you time to make necessary financial arrangements.

Insurance: Insurance benefits are determined by your employer and NOT your dentist. **Any deductible or estimated co-payment amount will be due at the time of treatment.** Insurance is **not a guarantee of payment**; they will not pay for all of your costs. You insurance policy is a contract between you and your insurance company. **Your insurance and payment are still your responsibility**. As a courtesy, we will be glad to file your claim for you if you bring 1) your dental insurance card 2) all required employer information. You will be expected to pay services rendered if this office is unable to verify your insurance information before treatment.

IF PAYMENT FOR SERVICES ALREADY RENDERED HAS NOT BEEN PAID IN FULL WITHIN 45 DAYS, EITHER BY YOU OR YOUR INSURANCE COMPANY, THE REMAINING BALANCE FOR ANY TREATMENT IS CONSIDERED DUE AND COLLECTIBLE FROM YOU.

We reserve the right to charge and collect fees for all appointments cancelled or failed without 2 working days advance notice. A $50.00 charge will be assessed to your account and will need to be paid before your next scheduled appointment. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Returned check fee of $25.00 will be added to your account balance and is collectable.

Separated/Divorced Parent of Minors who are each responsible for a portion of the cost of a child/children's dental care: The parent who brings the child to the appointment is responsible for paying the co-payment or full fee.

Payment plans and financial arrangements are offered through Care Credit. Applications are available in our office.

Due to the nature of health and dental care, there are no warranties or guaranties on treatment, implied or explicit, that is performed in this office. We reserve the right to charge for procedures as the necessity occurs with agreement to pay by the patient. We also reserve the right to charge an office visit fee or examination fee for doctor's time spent with a patient.

I have read and understand this financial policy.

Patient Signature: _____ Date: _____

Patrick L. DelFlore, D.D.S.
931 Centre Circle
Altamonte Springs, FL 32714
407-788-8388

Acknowledgement of Receipt of Privacy Practice Notice

Patient Name: _____

Address: _____

Phone Number: _____ Email: _____

Social Security Number: _____

I, _____ acknowledge that I have received a notice of Privacy Practice from the above named practice.

Signature: _____ Date: _____

For Office Use Only – Do Not Write Below This Line

Good faith effort to obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

_____

Describe the reason why the individual would not sign this form:

_____

_____

_____

I attest that the above information is correct:

Signature: _____ Date: _____

Print Name: _____ Date: _____