Tumminia Dental Associates, PA

Kathryn E Kolovani-Tumminia, DMD

7730 Boynton Beach Boulevard, Ste 6
Boynton Beach, FL 33437
(561)736-1900
(561)736-1966 Fax

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

If this appointment is for **YOU** start here

DATE:			
NAME:			
SPOUSE:			
ADDRESS:			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.	REFERRED TO US BY:		

If this appointment is for your **CHILD** start here

DATE:			
NAME:			
SPOUSE:			
ADDRESS:			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL	GRADE		
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	S.S.#	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
EMPLOYER	OCCUPATION	
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS PHONE NO.		
YOUR SPOUSE		
NAME		
EMPLOYER	OCCUPATION	
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS PHONE NO.		

FEES AND PAYMENTS: Payment is expected upon completion of each visit. Other arrangements can be made with our Office Manager depending upon special circumstances. An estimate of the charge for any procedure you may require will be given to you before treatment. If you have any dental insurance we will be glad to fill out the proper forms. Please remember insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance or any other balance not paid by your insurance company

PATIENT NAME ____ DATE ______________________

Primary reason for this dental appointment: ( ) Examination ( ) Emergency ( ) Consultation

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Yes No Describe ______________________________
Do you have dental examinations on a routine basis? Yes No Last visit ______________________________
Do you think you have active decay or gum disease? Yes No Do you brush and floss on a routine basis? Yes No
Do you have clicking, popping or discomfort in the jaw joint? Yes No Do you brux or grind? Yes No
Do you have any sores or growths in your mouth? Yes No Do you ever smoke or chew? Yes No
Name of previous Dentist (optional): ____
Date of last full mouth x-rays (18 small films or panoramic): ____

MEDICAL HISTORY

Are you under a physician's care now? Yes No Who? Why? ______________________________
Have you ever been hospitalized or had a major operation? Yes No Discuss ______________________________
Have you ever had a serious injury to your head or neck? Yes No Discuss ______________________________
Are you taking any medication, pills or drugs? Yes No What? ______________________________
Are you allergic to any medications or substances? Yes No Please check below
( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex Rubber ( ) Epinephrine ( ) Other _________
WOMEN (Please check): ( ) Pregnant/trying to get pregnant ( ) Nursing ( ) Taking contraceptives Discuss _____________

- **If yes to any of the below starred conditions, please call prior to your appointment…. Premedication may be required**

Please circle YES or NO below

Heart Trouble/Disease	Yes	No	Hemophilia (Bleeding)	Yes	No	Recent Weight Loss	Yes	No	AIDS	Yes	No
Heart Murmur	Yes	No	Leukemia	Yes	No	Frequent Diarrhea	Yes	No	HIV Positive	Yes	No
Irregular Heart Beat	Yes	No	Recent Blood Transfusion	Yes	No	Diabetes	Yes	No	Genital Herpes	Yes	No
Angina/Chest Pain	Yes	No	Swelling of Limbs	Yes	No	Excessive Thirst	Yes	No	Drug Addiction	Yes	No
Heart Attack/Failure	Yes	No	Lung Disease	Yes	No	Hypoglycemia	Yes	No	Cold Sores	Yes	No
Congenital Heart Disorder	Yes	No	Breathing Problem	Yes	No	Liver Disease	Yes	No	Fever Blisters	Yes	No
Mitral Valve Prolapse*	Yes	No	Shortness of Breath	Yes	No	Hepatitis A (Infectious)	Yes	No	Herpes	Yes	No
Scarlet Fever	Yes	No	Frequent Cough	Yes	No	Hepatitis B (serum)	Yes	No	Stroke	Yes	No
Rheumatic Fever*	Yes	No	Hay Fever	Yes	No	Yellow Jaundice	Yes	No	Convulsions	Yes	No
Artificial Heart Valve*	Yes	No	Sinus Trouble	Yes	No	Kidney Problems	Yes	No	Epilepsy or Seizures	Yes	No
Heart Pace Maker*	Yes	No	Asthma	Yes	No	Renal Dialysis	Yes	No	Fainting or Dizziness	Yes	No
Heart Surgery*	Yes	No	Emphysema	Yes	No	Thyroid Disease	Yes	No	Glaucoma	Yes	No
High Blood Pressure	Yes	No	Tuberculosis	Yes	No	Parathyroid Disease	Yes	No	Tumors or Growths	Yes	No
Low Blood Pressure	Yes	No	Cancer	Yes	No	Arthritis/Gout	Yes	No	Nervousness	Yes	No
Blood Disease	Yes	No	X-Ray Treatments	Yes	No	Rheumatism	Yes	No	Psychiatric Care	Yes	No
Bruise Easily	Yes	No	Radiation	Yes	No	Pain in Jaw/Joints	Yes	No	Alzheimer's Disease	Yes	No
Anemia	Yes	No	Chemotherapy	Yes	No	Cortisone Medicine	Yes	No	Allergies (Medicines)	Yes	No
Excessive Bleeding	Yes	No	Stomach/Intestinal Disease	Yes	No	Artificial Joint*	Yes	No	Allergies (Pollen/Dust)	Yes	No
Sickle Cell Disease	Yes	No	Ulcers	Yes	No	Venereal Disease	Yes	No	Hives or Rash	Yes	No

Have you ever had any other serious illness not checked above? Yes No Discuss ______________________________
Do you wish to talk to the dentist privately about any problem? Yes No
To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail

X____ Date ______________________

Patient Signature (Parent or Guardian)

Reviewed by Doctor ____ Date ______________________

DENTAL AND MEDICAL HISTORIES

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ___________________, understand that as a part of my healthcare, Tumminia Dental Assoc., P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Tumminia Dental Associates, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this contest or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Tumminia Dental Associates, P.A. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Tumminia Dental Associates, P.A. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use of disclosure of my health information:

____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept the terms of this consent.

____ _________________________

Patient's Signature Date

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MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

Name: ____ **Date of Birth:** __________________

Release of Information

( ) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

( ) Spouse: ____

( ) Child (ren): ____

( ) Other: ____

( ) Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

If unable to reach me:

( ) you may leave a detailed message

( ) Please leave a message asking me to return your call *(BY CHECKING THIS BOX IT MEANS WE ARE NOT ALLOWED TO LEAVE A MESSAGE CONFIRMING YOUR APPOINTMENT)*

Signed: ____ Date: ____/____/____

Witness: ____ Date: ____/____/____

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OFFICE POLICIES

1. Our office requires at least 24 hours notice if you are canceling a scheduled appointment.(If the appointment is on a Monday, we would need to hear from you by Friday a.m.) A broken appointment fee will be charged if prior notice was not given.

2. Please call the office if you are going to be late for your appointment. We might find it necessary to reschedule your appointment. Our office runs on a schedule, and when one patient is late, it will make the dentist run late for all of the following appointments. It is not fair to our other patients, who are on time to their scheduled appointments, to make them wait due to your tardiness.

3. Please turn your cell phone off upon entering the operatory for treatment.

4. Payment is due at the time of service. Patients with insurance are expected to pay all deductibles and co-insurance amounts at the time of service. Our office does call your insurance company for a general breakdown of your benefit structure, however, patients are expected to know their specific benefit plan. Insurance plans are structured through your employer and can vary in coverage. Please call your insurance company before any treatment is performed to make sure it will be covered. Patients will be responsible for any treatment fees which are not paid by their insurance company. We are happy to submit your dental claims for payment, however, patients are ultimately responsible for any unpaid balance over 30 days from the date of treatment. Please make sure your insurance company pays in a timely manner.

5. Due to the new HIPAA laws and privacy of our patients, we must ask parents and spouses to remain in the waiting room at all times, unless called upon by a staff member for you to accompany that patient. It is prohibited for anyone other than the patient to be allowed in the hallways or treatment areas.

6. Please do not leave children unattended in the waiting room or restroom. As a courtesy to other patients, please straighten up all toys, books and magazines your children have played with before you leave the office. No food or drinks are allowed in the waiting room at anytime.

7. All record requests must be submitted in writing and signed for by the patient or legal guardian only. Please give at least 24 hour notice for the duplication of x-rays and/or records. In accordance with Florida statutes, original x-rays cannot leave the office and must remain a part of a patient□s dental record for 7 years. A fee for the duplication of radiographs will apply unless our office has referred the patient to a specialist.

Signature:____ Date:__________________

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FINANCIAL POLICY

PATIENT NAME: ____

Payment is expected at the time services are rendered. Patients with insurance are expected to pay all deductible and co-insurance amounts on the date of service. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. We are happy to submit claims on our patient's behalf but patients are ultimately responsible for any balance not paid by the insurance company.

Treatment plans are only an estimate of what the insurance company will cover according to your benefit plan. The treatment plans are based on information we are given over the telephone and NOT a guarantee of payment. Our office obtains a **basic** breakdown of benefits from the insurance company before your appointment but all employers have different benefit structures and it is impossible for our office to know each individual plan's coverage restrictions. Please call your insurance company or check your benefit packages for coverage information. You may also ask our office to send in a pre-determination of benefits which usually takes 30 days to get the pre-authorization from the insurance company.

Any dental treatment which involves the use of an outside lab must be paid in full before the case will be delivered to the patient. There will be no exceptions. The office will collect half of the total fee for any procedure which requires an outside lab upon the impression appointment and the remaining balance will be due upon delivery.

Any balance which is considered past due will be subject to a late fee and interest of 1.5%. If any balance remains unpaid and it is necessary to send the account to an outside source for collection procedures, you will be responsible for any and all collections costs and fees.

I have read and understand the above financial policy.

____ ________________
Print name Date

____
Signature of patient or guardian

____
Relationship to patient