



Welcome!

Welcome to our practice! We appreciate the trust you have shown in us by selecting our office to provide your dental care. We are committed to providing you with quality dental care in a caring, gentle manner.

Following, you will find our patient information form, including health history, office financial policy, our Notice of Privacy Practices and acknowledgement for the NOPP. Please take the time to fill out these forms completely and accurately; this will ensure your allotted time will be maximized.

When we make appointments, your scheduled time is for you and the doctor. If for some unforeseen reason you must change your appointment time, please give us 48 hours' notice. We understand that things happen unexpectedly, and we will try to accommodate today's busy schedules.

Thank you again for choosing us for your dental care!

Welcome to Our Practice

Please take a few minutes to fill out this form as completely as you can.
If you have questions we'll be glad to help you. We look forward to working
with you in maintaining your dental health.

Patient Information

Date _____ Home Phone _____ Cell Phone _____
Mr. Mrs. _____
Ms. Dr. Name _____ Preferred Name _____
Last First Initial
Address _____ Apt # _____ Soc. Sec. # _____
City _____ State _____ Zip _____
Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Child ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
EMAIL ADDRESS _____
Patient Employed by _____ Occupation _____
Business Phone _____ Ext. _____ Whom may we thank for referring you? _____
In case of emergency, _____ Relationship _____ Phone # _____
who should be notified?

Acct. Info

Person Responsible for Account _____ Relationship _____
Address _____ City _____ State _____ Zip _____
(If different from patient)
Home Phone _____ Cell Phone _____ Work Phone _____

Dental Insurance

Subscriber _____ Last Name First Name Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Employer _____
Insurance Company _____ Ins. Phone # _____
Contract # _____ Group # _____ Subscriber # _____
Dependents covered on this plan _____

Please Complete Both Sides



Health History

Dental History

Reason for Today's Visit _____

Former Dentist _____ Phone # _____

Date of last dental care _____ Date of last dental X-rays _____

Check (✓) if you have had problems with any of the following:

- | | | | |
|--|---|--|---|
| ☐ Bad breath | ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ Sores or growths in your mouth |
| ☐ Bleeding gums | ☐ Grinding teeth | ☐ Sensitivity to hot | ☐ Chewing gum habit |
| ☐ Clicking or popping jaw | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets | ☐ Fingernail biting habit |
| ☐ Jaw pain | ☐ Periodontal treatment | ☐ Sensitivity when biting | |
| ☐ Other _____ | | | |

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Physician's Name _____ **Phone #** _____ **Date of your last visit** _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- | | | | |
|---|--|--|--|
| ☐ AIDS | ☐ Chemical Dependency | ☐ Hepatitis Type _____ | ☐ Radiation Treatment |
| ☐ Acid Reflux | ☐ Chemotherapy | ☐ High Blood Pressure | ☐ Psychiatric Care |
| ☐ Artificial Joints | ☐ Diabetes | ☐ HIV Positive | ☐ Respiratory Disease |
| ☐ Premedication for Dental Treatment | ☐ Epilepsy | ☐ Kidney Disease | ☐ Sleep Apnea |
| ☐ Asthma | ☐ Glaucoma | ☐ Liver Disease | ☐ Stroke |
| ☐ Back Problems | ☐ Headaches | ☐ Mitral Valve Prolapse | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Heart Problems | ☐ Nervous Problems | ☐ Tobacco Habit |
| ☐ Cancer | Describe _____ | ☐ Pace Maker | ☐ Tuberculosis |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Persistent Cough | ☐ Venereal Disease |

MEDICATIONS ☐ Yes ☐ No IF yes, list ALL MEDICATIONS

REASON

DRUG ALLERGIES ☐ Yes ☐ No

- | | | |
|--|---|--------------------------------------|
| ☐ Aspirin | ☐ Iodine | ☐ Penicillin |
| ☐ Barbiturates (Sleeping pills) | ☐ Latex | ☐ Sulfa |
| ☐ Codeine | ☐ Local Anesthetic | ☐ Other _____ |

Authorization

Signature _____ Date _____



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective
Notice of Privacy Practices for Twyla J. Roberts, DMD

this ____ day of _____, 20____.

A copy of this signed, dated Acknowledgement shall be as effective as the original.

I give my permission to discuss my dental treatment with the following person(s):

Please **print** your name

Please **sign** your name

If you are the legal representative of the patient, please print the patients' name(s) and
describe your authority _____.

You May Refuse to Sign This Acknowledgment

Thank you and if you have any questions about this form or the attached Notice, please
contact our privacy officer at (352)-373-7361.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this
Acknowledgment but did not because:

It was emergency treatment	_____
I could not communicate with the patient	_____
The patient refused to sign	_____
The patient was unable to sign because	_____
Other (please describe)	_____



OFFICE FINANCIAL POLICY

As your dental professionals, we are committed to providing you with the best possible dental care. In order to achieve this goal, we need your assistance, and your understanding of our financial policy.

PAYMENT FOR SERVICE IS DUE AT TIME SERVICE IS RENDERED. We accept cash, personal checks, and all major credit cards. Returned checks are subject to a service charge of \$35.00.

CHANGE OF APPOINTMENT: PATIENTS WHO DO NOT GIVE AT LEAST 2 BUSINESS DAYS' NOTICE WHEN CANCELING OR RESCHEDULING APPOINTMENTS WILL BE CHARGED A BROKEN APPOINTMENT RANGING FROM \$75 TO \$200. **INITIAL** _____

FINANCIAL AGREEMENT: We will gladly discuss your proposed treatment and do our best to answer any questions related to it. You must realize however:

We do not offer any in-office payment plans; however, payment arrangements can be made through Care Credit.

Any account balance not paid within 30 days will incur a finance charge. Account balances unpaid after 90 days will be sent to an outside collection agency.

We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, you must contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help.

I have read and understand the above financial policy.

Signature

Date

PATIENT PHOTOGRAPH CONSENT

I give Magnolia Family Dental to use my "before" and "after" photos for educational and marketing purposes.

My name will not be used and only the lower portion of my face will be included.

Signature

Date



INSURANCE AGREEMENT

Most importantly, please know our treatment is based on the dental needs of the patient, not the insurance company benefits.

1. As a service to our patients, we will do our best to **estimate** what your insurance company will pay. We will file your claim for you and we will collect your deductible, co-payment and fees for any non-covered services at the time of service.
We are not responsible for how your insurance company pays your claim. We cannot possibly know every clause in your dental contract.
2. **As a patient, I am aware that the office of Dr. Roberts is an in-network contracted PPO provider for Sunlife Financial, Aetna, Cigna Radius, GEHA Federal, and Blue Dental Choice Plus only. INITIAL _____**
3. All other insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract in any way. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services that they will not cover. Whether your insurance plan pays based on a fee schedule, allowance, or usual and customary, you may receive a statement for the portion your insurance did not cover, even after you paid your co-payment. If your insurance fails to pay their portion within 75 days from the date of service, the entire balance will be due from you. You can then obtain reimbursement from your insurance company.
4. For any account 30 days past due a monthly finance charge will be applied unless prior arrangements have been made
5. Accounts with a balance over 90 days will be sent to an outside collection agency. Any service fee incurred by the agency will be your responsibility

I _____ agree to accept the standard fees of this office despite my insurance benefit agreement. I am aware that there may be a difference in the insurance plan fee and the standard fee.

Any questions regarding your insurance coverage, please feel free to ask.

Name (Printed)

Signature

Date

DELTA DENTAL PATIENTS: Please be aware that these companies do not send payment to an out of network provider. Therefore, full payment of services rendered is expected on the date of your visit.