Atlantic Florida Dental, Inc. Implant Questionnaire

Patient Name:_______________________________________ Staff Member: ______________________

B/P: ______________________________

Prior Consult: YES or NO Where: _________________________________

Did you bring X-Rays / Treatment Plan: YES or NO

Budget: _______________________________________ Reviewed / Received Implant Booklet: YES or NO

Main Concern Upper or Lower or List: ____

1. How can we help you today? ____
2. Are you in Pain? YES or NO If so where? ____
3. Do you smoke? YES or NO
4. Do you have dental insurance? YES or NO If yes, what company: _________________________
5. Do you have a local medical doctor? YES or NO If yes, name: _____________________________
6. Any medical issues? YES or NO If yes, what:____
7. List medications you take if any: ____
8. Do you take or have you taken Bisphosphanates? YES or NO
9. If you are considered a candidate for dental implants can you start your case within 2 weeks? YES or NO
10. If you are prequalified for AFD's no interest financing over the course of your treatment do you need us to qualify you for extended financing? YES or NO
11. Budget: ____________________________________
12. Are you aware implant fees in area are $2500.00 or more per implant only? YES or NO
13. Questions: ____
14. The AFD, Inc. $1899.00 is for the implant/abutment and crown and does not include the grafting and extraction.

Atlantic Florida Dental

Date: ___________

Welcomes You

Last Name: _______________________________________ First Name: _______________________________________ M.I. _______

Home Address: ____

City: ____ State: ____________________ Zip: ________________________

Home Telephone: ____ Cell Phone: __________________________ Age: _______________ DOB_______________

Sex: Male or Female Marital Status: Single, Married, Divorced, Separated or Widowed

Social Security #: ______________________________________ Dr,Lic #: ____

List Major Credit Card #: ____

Employed By: ____ Business Phone: ____

Business Address: ____ City: ___________________________ State: _____________ Zip: __________

Person to call in case of an emergency: Name:_____________________________ Relationship:__________________________ Phone: _______________________

How are you paying for today's appointment: Cash_________ Credit Card________ Check________ Insurance________ Other________

By what means were you referred to our office? ____

Name of the person referring you or advertising method: ____

Are you under any HMO or PPO plan? If so name: ____ Group #____________________________________

General Health Questions

1. **Do you have or have you had any of the following? Please CIRCLE the condition:**

Heart Attack/Heart Trouble	Thyroid Disease	Open Heart Surgery
Mitral Valve Prolapse	Congenital Heart Disease	Valve Replacement
Rheumatic Fever/Murmur	Anemia/ Blood Disorders	Nervous Disorder
Blood Pressure (High or Low)	Arthritis/ Night Sweats	Asthma/ Hay Fever/ Emphysema
Stroke/Kidney Disease	Diabetes/ Fainting Spells	Glaucoma/ Tumors or Growth
Heart Murmur/Fever	Migraine Headaches	Hepatitis/ Liver Disorders
Extreme Weight Loss/ Anorexia	Cancer Treatment	Radiation Treatment
Ulcers/ Prostate problems	Herpes Virus	Tuberculosis/ Blood Sputum
Allergic to nickel or other metals	Epilepsy/ Seizures	Venereal Disease/ Persistent Cough
Periodontal Surgery	HIV Positive	Pregnancy- # of Months ________
	TMJ Problems	

Initials of DDS reviewing medical HX: _________________

2. **Are you under the care of a physician at this time?............... YES NO**
   If yes why? ____
3. **Are you taking any drugs or medications?............... YES NO**
   If yes , note name and dosage of each____
   Blood Thinners or Cortisone-like?............... YES NO
4. **Are you allergic or have you reacted adversely to any medication, food or other, or local anesthetic? YES NO**
   If yes, what? ____
5. **Have yohu ever had knee or joint replacement or pins inserted?............... YES NO**
6. **Have you ever had any bleeding or clotting problems or bruise?.............. YES NO**
7. **Do you usually heal quickly?............... YES NO**
8. **Do you bleed a long time or bruise quickly or ever had a blood transfusion?.............. YES NO**
9. **Ever had teeth extracted or any oral surgery?.............. YES NO**
   Any difficulties? If yes explain____
10. **Do you smoke?.............. YES NO**
11. **Have you ever been hospitalized with an undiagnosed condition?.............. YES NO**
    If yes what is the illness or operation____

Do you have any disease not listed above? Explain____

Dental Health Questions

Due to A.F.D's philosophy of reasonable fees it is imperative that the charges incurred for every appointment be paid in full for services rendered. This enables us to maintain our reasonable fees, to be passed on to all our patients. On all lab procedures, two thirds is requested to send the case out for lab work/processing and the remaining balance due day of delivery/insertion. All implant surgeries require a deposit to book the Surgical Appointment.

Why are you here today?____ Emergency_________________________________

Are you having pain now? **YES** **NO**

Are you interested in replacing missing teeth? Implants __________ Dentures __________ Crowns/Bridges __________

Are your teeth sensitive to: Heat __________ Cold __________ Sweets __________

Does food catch between your teeth? **YES** **NO**

Do your gums bleed when brushing? **YES** **NO**

Have you noticed any gum swelling around your teeth? **YES** **NO**

Do you smoke? **YES** **NO** Any tooth mobility present? **YES** **NO** Teeth Shifting? **YES** **NO**

Are you satisfied with your teeth and their appearance? **YES** **NO**

Do you have bad breath? _______________________________________ Last Cleaning Date: _______________________

When was your last dental appointment? ____

Why did you leave your last dentist? ____

Financial Arrangement

How are you paying today? Credit Card __________ Cash __________ Check __________ Ins __________ Other __________

Please see written financial policy attached

Payment options: Payment in full at the time of treatment:

We accept Mastercard, Visa, American Express, Discover, Care Credit and Debit Cards

Use of credit card authorizes A.F.D.Inc, payment in full with signature on file.

Dental Insurance Information

Name of Insurance Company: ____ Plan: _____________________________________

Name of Insured: ____ DOB of Insured: ______________________________

Relationship to patient: ________________________________ Employer: _____________________ Phone #: _________________

Authorization And Release

Note all dentist and independent contractors and carry their own malpractice insurance. I understand that the information that I have given today is accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history or contact information, insurance, etc… I authorize the dental staff to perform the necessary dental services for my treatment and or diagnosis. It is imperative that all charges incurred for every appointment be paid at that appointment. I authorize Atlantic Florida Dental, Inc. and its staff to perform the necessary surgery and or treatment.

Patient Name (print) :____ Witness: ______________________________________

Patient Signature: ____ Date: ____

Atlantic Florida Dental, Inc , Inc.
Notice Of Privacy Practices Short Form

Our practice is committed to educating our patients about healthcare issues that affect them. As a result we are providing you with federal information about the Privacy Rule, a federal regulation of the Health Insurance and Portability and Accountability Act of 1996. (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPAA and how does it affect you?
When the Health Insurance and Accountability Act (HIPAA) was passed in 8/96, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send patient's personal information as it related to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information? (IIHI)
Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another healthcare provider that related to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practices?
Our office has an official Notice of Privacy Practices posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This Notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our waiting room and you can ask for a copy of the current notice at any time.

The following categories describe unique situations in which we may use or disclose your IIHI:

Treatment	Appointment Reminders	Release to family/friends
Payment	Treatment Options	Disclosure by Law
Health Care Opt.	Health Related Benefits Services	

The following categories describe unique situations in which we may use or disclose your IIHI:

Public Health Risk	Health Oversight Activities	Lawsuits	Law Enforcement
Deceased Patients	Organ / Tissue Donation	Serious threats to Health or Safety	
Military	National Security Inmate	Workers Compensation	
Research			

What are your rights concerning your Individual Health Information (IIHI)?
You have rights regarding the IIGI that we maintain about you. In our Notice of Privacy you can review the policies and procedures you will need to follow the areas listed below.

1. Confidential communications
2. Requesting Restrictions
3. Inspection and copies
4. Amendment
5. Accounting Disclosures
6. Right to paper copy of this notice
7. Right to file a compliant
8. Right to provide an Authorization for Other Uses and Disclosures.

If you have any questions regarding this notice or health information privacy policies please contact:
Lisa Thorp
AFD Inc, Privacy Officer

I understand that I do not become a patient of record and do not have a dentist of record until the comprehensive exam is complete and a final treatment plan has been signed by me, the patient and the dentist. Today is a limited screening exam only.
If you request a complete copy of your chart, including x-rays, photos etc, the booking keeping dept. Charges a minimum of $55.00, request can take up to 14 days to process. All requests for records must be in writing and prepaid.

Signature ___________________________________ Print Name of Patient ______________________________ Date _______________________

Atlantic Florida Dental Inc.
260 E. Dania Beach Blvd. / Dania FL, 33004 / 9549221947

Written Financial Policy

Thank you for choosing Atlantic Florida Dental Inc. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy manageable for our patients' as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card
- Convenient Monthly Payment Plans from CareCredit*
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Atlantic Florida Dental Inc. requires payment prior to the completion of your treatment. IF you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

We accept payment in thirds for plans requiting multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $500 or more, a 20% deposit is required to secure tour initial treatment appointment.

Atlantic Florida Dental Inc. charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

AFD Inc. Cancellations and Broken Appointments

In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 24 hour cancellation notice. Your scheduled time has been saved only for you and the doctor and/or hygienist. Due to overhead that occurs in broken appointment slots, a cancellation fee is charged if a 24 hour notice is not given. Our message system will accept your cancellation calls for you and will record time/date of your calls to avoid a $50 charge per hour of scheduled appointment to your account. We appreciate your efforts to keep scheduled appointments and we will make every effort to continue to have convenient hours and prescheduled availability for you.

I / We understand the above paragraph regarding cancellation fees, and have had the opportunity to have any questions answered to the best of ability.

Signature of Responsible Party: ____ Date: ______________________________________

*subject to credit approval

PLEASE

STOP

HERE

(Last Name) (First Name) ADDRESS PHONE OFFICE CHART # ____

BUSINESS ADDRESS PHONE DENTIST OF RECORD - DATE

Referred by LIMITED EXAM PHYSICIAN ADDRESS PHONE

TREATMENT PLAN
Date ____________

CHIEF COMPLAINT

1.
2.
3.
4.

Diagnosis:

Notes:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Required on All Dentulous Patients

PERIODONTAL EVALUATION

STAIN	L	M	H
O.H.	G	F	P
PLAQUE	L	M	H
CALCULUS			
SUPRA	L	M	H
SUB	L	M	H

TISSUE CONDITION
HYPEREMIA ____
POCKETS ____
RECESSION ____
FOOD IMPACTION ____
MOBILITY ____
SENSITIVITY ____
SALIVA ____
OVERHANG ____
RECALL 2 3 4 5 6
PERIO CLASSIFICATION 1 2 3 4
PATIENT ACCEPTANCE YES NO

Biphosphonates Yes ☐ No ☐
Smoker Yes ☐ No ☐
Physician Consult Yes ☐ No ☐

MEDICAL ALERT

Date of Acceptance of Treatment Plan
Patient Given Handouts Yes ☐ No ☐
Patient shown Films Yes ☐ No ☐
Blood Pressure ___/___ Date
___/___ Date

Bruxism Yes ☐ No ☐
Crepitis Yes ☐ No ☐
Interincisal Opening ____ MM
Protrusive Distance ____ MM
Left Distance ____ MM
Right Distance ____ MM

TMJ EVALUATION Normal ____ Abnormal ____
HEAD & NECK EXAM Normal ____ Abnormal ____
Oral Cancer Exam Yes ☐ No ☐

Patient a member of C D P
ADP, Private, Denticare, HIP
IDP, OHS, Cigna, Other

NAME ADDRESS

DATE		DDS INS.	DESCRIPTION WORK AND ACCOUNT	Elig	CHARGE		AMOUNT PAID	BALANCE