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DENTISTRY OF PLANT CITY

Patient Registration

First Name:_____ Last Name: _____M.I:____Sex: ☐ Male ☐ Female

Date of Birth:_____Age:_____Soc. Sec. #:_____

Address:_____City, State, Zip:_____

Cell Phone:_____ Home Phone:_____Work Phone:_____

Email:_____Marital Status: ☐ Married ☐ Single ☐Divorced ☐Separated

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Pref. Pharmacy:_____

Responsible Party (If someone other than patient)

First Name:_____ Last Name:_____ M.I:____Date of Birth:_____

Address:_____ City, State, Zip:_____

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

Email:_____Soc. Sec. #:_____

Emergency Contact: Name:_____ Phone:_____Relation:_____

Primary Dental Insurance Information:

Name of Dental Insurance:_____ Address of Insurance:_____

Insurance Phone#_____Policy Holder:_____

Date of Birth:_____Policy Holder Address:_____

City, State, Zip: _____Member ID# or SSN: _____Employer:_____

Hussein Abdulameer, DDS

OFFICE@INSPIREDENTISTRYPC.COM INSPIREDENTISTRYPC.COM 1805 W. REYNOLDS ST, PLANT CITY, FL 33563

813-754-2605 813-752-7436

Inspired Dentistry Of Plant City

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now? ◯ Yes ◯ No If yes

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No

Have you ever been told to take Antibiotics before dental visits? ◯ Yes ◯ No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

Have you ever had an allergic reaction to local (Dental) Anesthetic? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Do you use controlled substances? ◯ Yes ◯ No If yes

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other Allergies? ◯ Yes ◯ No

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Are you suffering from COPD? ◯ Yes ◯ No

Do you have Auto-Immune Disease? ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Other illness

Signature of Patient, Parent or Guardian:

X Date:_____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Inspired Dentistry of Plant City may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): _____
Date of Birth: _____

I. My Authorization

I authorize _____ to use or disclose the following health information:

- ❏ All of my health information
- ❏ My health information relating to the following treatment or condition:

  _____
- ❏ My health information covering the period of healthcare from _____ (Start Date) to _____ (End Date).
- ❏ Other:_____

The above party may disclose this health information to the following recipient:

Name/Organization:

_____

Phone: _____ Fax: _____

Email: _____

The purpose of this authorization is (check all that apply):

- ❏ At my request
- ❏ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ❏ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
- ❏ Other:

  _____

  _____

  _____

This authorization ends:

- ❏ On (Date): _____
- ❏ When I am no longer a patient of the practice.
- ❏ When the following event occurs:

  _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my

permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____
Date: _____

If the patient is a minor or unable to sign please complete the following:

- ❏ Patient is a minor: _____ years of age
- ❏ Patient is unable to sign because:

  _____

Authorized Representative Signature: _____

Date: _____

Print Name of Representative:

_____

Authority of representative to sign on behalf of patient:

❏ Parent ❏ Legal Guardian ❏ Court Order ❏ Other: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

❑ I consent ❑ I do not consent

Signature of Patient or Authorized Representative:

_____

Date: _____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

❑ I consent ❑ I do not consent

Signature of Patient or Authorized Representative:

_____

Date: _____ Time: _____

V. Notice of Privacy Practices

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative:

_____

Date: _____ Time: _____

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DENTISTRY OF PLANT CITY

FINANCIAL AGREEMENT

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:

1. Cash
2. Check
3. Mastercard
4. Visa
5. Discover
6. Care Credit
7. American Express

Patient with Insurance: The patient is responsible for the ESTIMATED non-covered portion, procedures, and/or deductibles at the time of service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid their portion of the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their children to an appointment must make PRIOR arrangements for payment. Parents accompanying their children are financially responsible for payment.

18% annual intertest is charged for any unpaid balance. There is a $30.00 processing charge for non-sufficient funds or returned checks. Because instruments, chairs, and personnel are reserved exclusively for your appointment.

I, _____ agree to these financial terms.

Signature: _____ Date: _____

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