REGISTRATION FORM Section I: Patient Information

Date: _____
Name: _____ SSN: _____-____-_____
Date of Birth: _____

Address: _____ _____ City: _____ State: _____
Zip: _____
Phone: (_____) _____Work Phone: (_____) _____
Cell Phone: (_____) _____

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Employer: _____ Work Phone: _____

Whom may we thank for referring you? _____Email:_____

Emergency Contact: _____ Phone: _____

Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II Responsible Party (if other than you)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____) _____
Employer: _____ Work Phone (____) _____
SSN#: _____

Section III Insurance Information (if None, skip this section)

Name of Main Insured: _____ DOB: _____
Relationship to Patient: _____
SSN#:_____ Name of Employer: _____
Work Phone: (____) _____
Address of Employer: _____City: _____ State: _____
Zip: _____

Insurance Company: _____ Grp #: _____
ID#: _____

Ins Co Address: _____
Ins Co. Phone: _____

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Section IV **Dental History**

Name: _____

Reason for today's visit: _____

When was your last cleaning:

_____

Check if you have any problems with the following:

☐ Bleeding Gums ☐ Grinding Teeth ☐ Sores or growths in your mouth
☐ Clicking or popping of jaw ☐ Loose teeth or broken fillings ☐ Broken Teeth

Is there anything about the appearance of your teeth that you are unhappy with or would like to improve?

Section VI **Medications**

List any medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section VI **Allergies (If none, Check None)**

☐ **None**

☐ Latex ☐ Penicillin
☐ Barbiturates (Sleeping Pills) ☐ Sulfa
☐ Codeine ☐ Metal Allergies
☐ Local Anesthetic
☐ Aspirin

Other_____
_____
_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Doctor Signature: _____Date:_____

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Section V Medical History

Name: _____ Date:_____

Physician's Name: If none, write None. _____

Date of last Visit: _____

Physician's Phone number _____

Have you had any serious illnesses or operations? _____ If yes, please describe and date_____

_____

Have you had a history of radiation therapy? ☐ Yes ☐ No Dates, if applicable _____

Have you ever had a blood transfusion? ☐ Yes ☐ No Dates, if applicable: _____

Are you taking any blood thinners? (Aspirin, Plavix, Coumadin etc.) _____

(Women) Are You Pregnant? ☐ Yes ☐ No How long? _____ Taking Birth Control? ☐ Yes ☐ No

Are you taking any bisphosphonates? (Actone, Fosamax) _____

Check if you have any of the following: Check None, if you don't have any of the following or Fill out Other Section.

☐ **None**

☐ Diabetes	☐ Hepatitis/Liver Problem	☐ Pacemaker	☐ Dialysis
☐ Artificial Heart Valve	☐ Epilepsy	☐ Herpes	☐ Rheumatic Fever
☐ Artificial Joints	☐ Fainting	☐ High Blood Pressure	☐ Scarlet Fever
☐ Asthma	☐ Heart Murmur	☐ HIV Positive	☐ Thyroid Problems
☐ Back Problems	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Stroke	☐ Excessive Bleeding	☐ Aids

☐ Heart Problems – Describe: _____

Do You Smoke? Yes/No How much per day? _____

Other/Notes:

_____

_____

_____

Patient Signature: _____

Doctor Signature: _____

Office USE ONLY BELOW:

Medical Release Necessary? _____ Physician #: _____

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Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party-payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying to this consent.

1. Information to be Used or Disclosed:
   __ My dental records for the following date(s):_____ or
   __ Entire dental record
   __Include__ Exclude: My health information related to drug and/or alcohol abus
   __ Include __ Exclude: My health information related to HIV/AIDS
   __Other information to be used or disclose (describe information in detail): _____
   _____
2. Purpose of Use or Disclosure:

   __ Treatment, Payment or Dental Care Operations
   __ Disclosure to Life Insurer for Coverage Purposes
   __ Disclosure to Employer of results of pre-employment physical or lab tests
   __ Release to the Following Family Members:_____
   _____
   __ Other (describe each purpose of the requested use and disclosure in detail):

3. Person(s) Authorized to Make the Disclosure: _____

4. Person(s) Authorized to Receive the Disclosure: _____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Patient Name: _____Date: _____

Signature: _____ Date: _____

Relationship to Patient: _____

2425 Brunello Trace Lutz, Fl 33558

luminasmiles@gmail.com 813-406-4848

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GENERAL, SURGICAL & COSMETIC DENTISTRY

Financial Policy

In consideration for undertaking my care, I agree to the following:

I accept full financial responsibility for the services provided to me by Lumina Dental and I understand that payment is due at the time of service or before. This includes emergency visits for me or any of my dependents, or at the initiation of service under a treatment plan that I or my dependents have requested.

If you have insurance, we will provide an **estimate** of what we think your insurance company will **probably** pay and collect the difference from you. I understand that my insurance company may not cover all necessary balances and may send the check to the wrong party. In the event that the insurance company mistakenly sends a reimbursement check to me for services that were rendered but not previously paid for I will endorse the check to Lumina Dental within 5 business days of said payment. You will be billed any amount not paid by the insurance company. Payment is expected upon receipt of statement. If payment is not paid in a timely fashion, we reserve the right to process full payment on your pre-setup payment plan.

(_____)**Initials**

If the insurance company pays more than we expected, you will have a credit on your account. We will mail you a statement informing you of the credit. You can keep it on your account or we can refund it to you. All outstanding insurance claims must be received before we may issue any refunds. Please allow 6-8 weeks for processing.

We will try to arrange payment from your insurance company for a maximum of 60 days. After 60 days, you are fully responsible for any balance on your account, regardless of whether your insurance company has paid us or not.

I understand that all insurance claims from treatment that I receive from Lumina Dental are being filed by Lumina Dental with my authorization as a courtesy to me and are subject to review by my insurance carrier. I understand that Lumina Dental will file a claim with my insurance carrier up to two times per appointment and that any further insurance appeal is solely my responsibility. I also acknowledge that I am solely and ultimately responsible for paying all charges not covered by my insurance for any reason, including but not limited to, my insurance denying coverage for any procedure, policy deductibles, policy annual maximum, or lifetime benefits exceeded, my insurance paying an amount for a procedure based on its usual and customary benefit schedule which is less than the fees charged by Lumina Dental for such a procedure and Lumina Dental not receiving payment within 60 days of the procedure being performed even if I am appealing the denial of insurance benefits by my carrier.

I understand that If I opt to discontinue treatment for a procedure requested be completed by Lumina Dental, including but not limited to , Partial Dentures, Crowns, Bridgework, Surgical Preparatory work, impressions, I will be responsible for paying all costs for materials, Lab Bills, and services including administration and fees associated with chair time, that were provided for my benefit prior to my decision to discontinue such treatment and that all such cost and discounts given will be deducted from any refund that I may be entitled to as a result of any prepayments for the requested services.

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Cancelled appointments may also result in administrative charges that will be charged to the payment plan that was set up for you.

I understand that if a check, or any instrument, or any electronic authorization or debt sent or provided to Lumina Dental for payment is not honored upon first presentment, regardless of the reason, even if the check, instrument, or electronic authorization is later honored, I will be charged a service charge. The charge is currently **$25.00** and is subject to change without notice.

When we reserve time for your appointment, we make room in our schedule so we may devote our time and focus our efforts on serving your needs. Late cancellations force us to have empty time in our schedule when we could have been helping another patient. There is a **$40.00** charge for reserved appointments broken or changed without a 48 hour notice for general dentistry and a **$250** charge reserved for our Specialist appointments without a 48 hour notice.

Initials (_____) **I understand that minor children are not permitted in the operatories. They are welcome to wait in the lobby while being accompanied by an adult.**

Initials (_____) **I understand that the charge for copies of X-rays and treatment information is currently $15.00 and is subject to change without notice.**

Patient Name

Signature or Guardian Date

2425 Brunello Trace Lutz, Fl 33558

luminasmiles@gmail.com (813)406-4848