Gulf Dental

151 Mary Esther Blvd., Suite 402
Mary Esther, FL 32569

Patient Information

Patient Name _____ Date _____
Last First MI

Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ☐

Social Security # _____ Birth Date _____

Phone (Home) _____ (Work) _____ Ext_____ (Cell) _____

Email address _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Are you happy with your smile? ☐ Yes ☐ No

What would you like to change? _____

Have you ever used, or do you currently use, tobacco products? ☐ Yes ☐ No

If yes, which products? ☐ Cigarettes/Cigars ☐ Chewing Tobacco ☐ Vaping ☐ Other _____

Have you ever had any of the following? Please check those that apply.

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ *Stomach Problems*
☐ *Allergies*_____	☐ *Fainting*	☐ Mental Disorders	☐ Stroke
_____	☐ *Glaucoma*	☐ *Nervous Disorders*	☐ Thyroid problems
☐ *Anemia*	☐ *Growths*	☐ Osteoporosis	☐ Tuberculosis
☐ *Arthritis*	☐ *Hay Fever*	☐ Pacemaker	☐ *Tumors*
☐ Artificial Joints	☐ *Head Injuries*	☐ *Pregnancy (current)*	☐ *Ulcers*
☐ Asthma	☐ Heart Disease	*Due date*:_____	☐ Codeine Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Radiation Treatment	☐ Latex Allergy
☐ Cancer	☐ Hepatitis	☐ *Respiratory Problems*	☐ Penicillin Allergy
☐ Diabetes	☐ High Blood Pressure	☐ *Rheumatic Fever*	☐ *Smoking*
☐ *Dizziness*	☐ *Jaundice*	☐ *Rheumatism*	☐ Other
☐ Epilepsy	☐ Kidney Disease	☐ *Sinus Problems*	☐ _____

Do you take antibiotics prior to dental treatment? ☐ Yes ☐ No

Are you on a blood thinner? ☐ Yes ☐ No If yes, what is the name of the medication? _____

Have you ever taken Bisphosphonates? (Bone density medications) ☐ Yes ☐ No

Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain._____

EMERGENCY CONTACT

_____
NAME NUMBER RELATIONSHIP

PHARMACY INFORMATION

_____
Pharmacy Name

_____
Pharmacy Number Address

Medications currently taking:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have changes in my health, I will inform the doctor at the next appointment without fail.

_____ Date _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? □ Another patient, friend □ Another patient, relative
□ Dental Office □ Yellow Pages □ Newspaper □ School □ Work □ Other_____

Name of person or office referring you to our office _____

Spouse or Responsible Party Information (if different from patient)

The following is for □ the patient's spouse □ the person responsible for payment
Male □ Female □ Married □ Single □ Child □ Other □

Social Security # _____ Birth Date_____

Phone (Home) _____ (Work) _____Ext_____ (Cell) _____

Email address _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for □ the patient □ the person responsible for payment

Employer Name _____ Occupation _____

_____
Address Phone number

Insurance Information

Name of Insured _____ Is insured a patient? □ Yes □ No
Last First MI

Insured Birth Date _____ ID# _____ Group # _____

Insured's Employer Name _____

Insured's Address: _____
Street City State Zip Code

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other

Insurance Plan Name: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimates listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore reasonable value of said services to said Doctor, or his assignee, at time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date _____Relationship to Patient:_____
Signature of patient, parent or guardian

_____ Date _____Relationship to Patient:_____
Signature of guarantor of payment/responsible party

GULF DENTAL
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(850) 796-2838

Financial and Insurance Policy

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients with insurance from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments. ***Please be aware that Dr. Mason is only in network with certain insurances. Please ask our staff to see if your insurance is in or out of network.***

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office, unless benefit is assigned to the patient per the insurance policy.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental plan to advise you of benefits available to you within limits of HIPPA, the privacy act.
4. Re-filing your insurance a second time within 40 days.
5. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment from some services, use restricted Fee Schedules and/or Usual and Customary Rates and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance and not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 60 days.
5. Taking responsibility for any portion of fees not paid by your insurance company.
6. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage.

Please sign below and have your insurance card ready for us to copy for your file.

I hereby authorize Mary Ann Mason, DMD to release to my insurance company information required in the course of my dental care. I hereby authorize benefits to be paid directly to Mary Ann Mason, DMD. I understand I am responsible for any unpaid balances.

_____
Please Print Name

_____ _____
Signature of Patient/Insured Date

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APPOINTMENT POLICY

Gulf Dental, LLC is a private dental office and our hours are scheduled 'by appointment only.' Appointment time is reserved for you alone and our staff wants to be available for your needs as well as the needs of our other patients. When a patient does not show up for their scheduled appointment or cancels at the last minute, another patient loses an opportunity to be seen.

We require a two-business day advance notice for any changes or cancellations of your appointment. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time. If less than a **48-hour** notice is given, you may be subject to a **$50.00** cancellation fee. We understand that illness and emergencies occur, and we do accommodate for those rare instances.

Families that enjoy the convenience of scheduling multiple members at the same time will gladly be accommodated as much as possible with the understanding that multiple, same-time appointments are often hard to find. Because of this, we stress that if such appointments are desirable, you must ensure that all appointed family members are able to keep their appointments.

Your continued respect for our appointment policy will ensure your prompt rescheduling if the need occurs.

_____

Patient or Guardian Signature

GULF DENTAL

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Mary Esther, FL 32569
Phone: 850-796-2838

Acknowledgement of Receipt of Privacy Practices Notice

Patient Name _____

I acknowledge that I have received and/or read a Notice of Privacy Practices from the above practice.

Signature _____ Date _____

Patient authorizes the release of information to the below listed people:

_____

_____