NORTH FLORIDA DENTISTRY
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Olga Tron, D.D.S.
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www.northfloridadentistry.com

Welcome

Patient Information

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Home ( ) _____

Work ( ) _____ Ext _____

Cell Phone ( ) _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____ Social Security # _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Occupation _____

Patient Employee/School _____

Employer/School Address _____

_____

Employer/School Phone ( ) _____

Spouse's Name _____

Spouse's Work ( ) _____

Cell# ( ) _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Subscriber/Insured's Name _____

Birthdate _____ Social Security # _____

Relationship to Patient _____

Subscriber's Employer _____

Address of Employer _____

City/State/Zip _____

Name of Insurance Company _____

Address of Insurance Company _____

City/State/Zip _____

Telephone of Insurance Company _____

Group# _____

Member ID # _____

If you do not have all of the above information for insurance filing, payment is due in full on date of service. You will be given a receipt that can be used for filing the claim yourself with direct reimbursement to you.

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. John Harrington/Dr. Olga Tron all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-names dentists may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Guardian or Personal Representative

_____
Please print name of Patient, Guardian or Personal Representative

_____
Date Relationship to Patient

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

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

Dental History

Reason for today's visit _____

_____

Former Dentist _____

Office Address _____

City/State/Zip _____

Telephone # of previous dentist _____

Date of last dental visit _____

Date of last dental X-rays _____

Bad breath	☐ Yes	☐ No		Loose teeth or broken fillings	☐ Yes	☐ No	
Bleeding gums	☐ Yes	☐ No		Mouth Breathing	☐ Yes	☐ No	
Blisters on lips or mouth	☐ Yes	☐ No		Mouth pain when brushing	☐ Yes	☐ No	
Burning sensation on tongue	☐ Yes	☐ No		Orthodontic treatment	☐ Yes	☐ No	
Chew on one side of mouth	☐ Yes	☐ No		Pain around ear	☐ Yes	☐ No	
Clicking or popping jaw	☐ Yes	☐ No		Periodontal treatment	☐ Yes	☐ No	
Dry Mouth	☐ Yes	☐ No		Sensitivity to cold	☐ Yes	☐ No	
Fingernail biting	☐ Yes	☐ No		Sensitivity to heat	☐ Yes	☐ No	
Food collection between the teeth	☐ Yes	☐ No		Sensitivity to sweets	☐ Yes	☐ No	
Grinding teeth	☐ Yes	☐ No		Sensitivity when biting	☐ Yes	☐ No	
Jaw pain or tiredness	☐ Yes	☐ No		Sores or growths in your mouth	☐ Yes	☐ No	
Lip or Cheek biting	☐ Yes	☐ No		How often do you floss? _____			
				How often do you brush? _____			

Health History

Name of Medical Doctor_____ Date of last visit _____

City/State _____ Telephone # _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" This includes combinations of Ionimin, Asiplex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type_____	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Smoker, tobacco user	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Drug addiction, alcohol	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No			
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			
Do you wear contact lenses?	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No			
			Rheumatic Fever	☐ Yes	☐ No			
			Scarlet Fever	☐ Yes	☐ No			

Do you Premedicate for dental appointments? ☐ Yes ☐ No

If yes, reason for Premedication: _____

Antibiotic taken: ☐ Amoxicillin ☐ Clindamycin ☐ Other _____

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

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills ☐ Yes ☐ No

Is it possible you could be pregnant? ☐ Yes ☐ No

Explain all YES answers: _____

_____

_____

_____

_____

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name_____

Phone_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Metal (nickel)

☐ Latex ☐ Other_____

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Financial policies

Dr. John Harrington, Dr. Olga Tron and Dr. Brittany Jones accept several forms of payment for dental treatment provided by this office. **Cash, personal check, credit Cards, MasterCard, Visa, Discover and American Express.**

Third Party Finance company: We offer care credit interest free financing to assist you in multiple monthly payments. Options for 6 & 12 months. The application process is easy and convenient via phone call or internet. This is a great opportunity to complete your dental treatment now!

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to provide reasonable assistance to help you maximize your benefits. Most dental insurance excludes coverage for some services, uses restricted fee schedules for most services, and can decline payment based on any number of policy restrictions and limitations. All such restrictions and limitations are based on the premium paid by your employer for the coverage, not on our fees or the treatment we recommend. We encourage you to become familiar with your policy: its coverage, exclusions, deductibles and maximums. **We recommend treatment appropriate to you dental needs regardless of your insurance status.**

Our courtesy service to our patients includes:
1. Filing your claim/s promptly and requesting that payment be sent directly to us.
2. Following American Dental Association guidelines for claims coding and filing.
3. Estimating your benefits to the best of our ability. Most insurance companies will not provide us with detailed information about your coverage, **so any insurance figures we provide you are only estimates!**

Our expectations of you as the insured patient and/or owner of the policy:
1. You will pay, at this time treatment, all fees not estimated to be covered by your insurance company.
2. You will assume responsibility for any amounts expected from your insurance company, not received within 60 days after treatment had been performed and the claim submitted. Please understand that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
3. You will pay any outstanding balances within 10 days upon receipt of statement.

I hereby authorize Dr. John Harrington, Dr. Olga Tron and Dr. Brittany Jones to release to my insurance company any information acquired in the course of my dental care. I authorize benefits to be paid directly to North Florida Dentistry. I understand I am responsible for all fees and/or contractual allowances incurred, regardless of the status of insurance. I understand that treatment cannot be completed until it is paid for (e.g, crowns will not be cemented, dentures will not be placed).

I understand that if I hold an unpaid balance older than 90 days it will be placed for collections action.

Patient Name: _____ Date: _____
(Please Print)
Responsible Party: _____ Date: _____
(Please Print)
Patient/Responsible Party Signature: _____

North Florida Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's Notice of privacy practices.

_____

Please Print Name

_____

Signature (if under age 18 parent/guardian signature)

_____

Date

List below any person(s) allowed to have information regarding your dental treatment/history.

_____

_____

_____For office Use Only_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledge could not be obtained because:

- ☐ Individual refused t sign
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledge
- ☐ Other (Please specify)

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance.

Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for No-show appointments, and those appointments not cancelled within 48 hours. **There will be a fee of $50.00 assessed if we do not receive a call to cancel an appointment.**

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

The staff of North Florida Dentistry

Patient Name: _____ Date: _____

Patient Signature: _____

North Florida Dentistry

Oral Cancer Screening Recommendations

Oral Cancer kills on e American every hour of everyday.

We have a new technology: Identafi 3000 Ultra that is FDA approved and allows us to screen for oral cancers and pre-cancers. This technology was developed in conjunction with M.D. Anderson Cancer Center and is manufactured in Houston. When Found early, oral cancer patients have a nearly 90 % survival rate. It involves using different wavelengths of light from a small portable hand-held device.

Symptoms

Early Indicators:

* Red and/or white discolorations of the soft tissues of the mouth.
* A sore that does not heal within 14 days.
* Hoarseness that lasts for a prolonged period of time

Advanced indicators:

* A sensation that sometimes is stuck in your throat.
* Numbness in the oral region.
* Difficulty in moving the jaw or tongue.
* Difficulty in swallowing.
* Ear pain which occurs on one side only.
* A sore under a denture that won't heal, even after adjustment of the denture.
* A lump or thickening which develops in the mouth or on the neck.

North Florida Dentistry recommends that all patients over the age of 21 be screened once a year for oral cancer. The test is simple, painless and takes less then 3 minutes.
Insurance companies are not covering this service at this time. The cost is $35.00.

____ **Yes,** I would like an annual Oral Cancer Screening.

____ **No,** I would not like an Annual Oral Cancer Screening.

Patient Name: _____

Signature: _____ Date: _____