

PATIENT INFORMATION

Patient's Name _____ Nickname _____

Address _____
STREET CITY STATE ZIP

Social Security # _____ Birthdate _____ Home Phone _____
Cell Phone _____

Employer _____ Occupation _____ Work Phone _____

Parent or Guardian (if patient is a minor) _____

PERSON RESPONSIBLE FOR PAYMENT

Name _____ Relationship _____

Address _____
STREET CITY STATE ZIP

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____

DENTAL INSURANCE

Insured's Name _____ SS# _____

Employer _____ Work Phone _____

Employer's Address _____ Contact Person _____

Insurance Company _____ Group # _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

INFORMATION AND CONSENT

I hereby authorize doctor to take x-rays or other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics or other medicines as necessary. I fully understand that dental treatment and anesthetic agents embody certain risks and that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other financial arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account.

Patient (Guardian) Signature _____ Date _____

REGISTRATION

All information is completely confidential.

NAME _____ DATE _____

1. PHYSICIAN'S NAME _____ CITY _____ PHONE _____

2. ARE YOU TAKING ANY MEDICINES OR DRUGS? YES NO (PLEASE LIST IF YES) _____

3. ARE YOU ALLERGIC TO ANY MEDICINES OR DRUGS? YES NO (PLEASE LIST IF YES) _____

4. HAVE YOU BEEN A PATIENT IN THE HOSPITAL DURING THE LAST TWO YEARS? YES NO

5. DO YOU HAVE A HISTORY OF CHEMICAL DEPENDENCY? YES NO

6. HAVE YOU HAD OR DO YOU HAVE AT PRESENT THE FOLLOWING? CIRCLE "YES" OR "NO" FOR EACH ITEM

- | | | | | | |
|--------------------------------------|-----|----|-------------------------------|-----|----|
| HISTORY OF ENDOCARDITIS | YES | NO | CHRONIC COUGH..... | YES | NO |
| CONGENITAL HEART DISEASE (CHD) | YES | NO | TUBERCULOSIS..... | YES | NO |
| ORGAN TRANSPLANT | YES | NO | ASTHMA..... | YES | NO |
| RENAL DIALYSIS | YES | NO | LATEX ALLERGY | YES | NO |
| HEART TROUBLE | YES | NO | DRUG ALLERGY..... | YES | NO |
| ARTIFICIAL HEART VALVE | YES | NO | CANCER | YES | NO |
| HEART PACEMAKER..... | YES | NO | RADIATION THERAPY..... | YES | NO |
| HIGH BLOOD PRESSURE | YES | NO | CHEMOTHERAPY | YES | NO |
| STROKE | YES | NO | HEPATITIS..... | YES | NO |
| ARTHRITIS | YES | NO | VENEREAL DISEASE OR STD | YES | NO |
| SPECIAL DIET | YES | NO | HIV OR AIDS | YES | NO |
| ARTIFICIAL JOINT REPLACEMENT | YES | NO | HEMOPHILIA..... | YES | NO |
| KIDNEY DISEASE | YES | NO | SICKLE CELL DISEASE..... | YES | NO |
| ULCERS | YES | NO | LIVER DISEASE..... | YES | NO |
| DIABETES | YES | NO | NEUROLOGICAL DISORDER..... | YES | NO |
| THYROID PROBLEMS | YES | NO | EPILEPSY OR SEIZURES | YES | NO |
| GLAUCOMA | YES | NO | FAINTING OR DIZZY SPELLS..... | YES | NO |
| EMPHYSEMA | YES | NO | PSYCHIATRIC CARE..... | YES | NO |

7. LIST ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE _____

8. WOMEN: ARE YOU **PREGNANT?** YES NO **NURSING?** YES NO **TAKING BIRTH CONTROL PILLS?** YES NO

9. PERSON TO NOTIFY IN CASE OF AN EMERGENCY _____ PHONE _____

"I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication."

SIGNATURE _____ DATE _____

FOR DR. ONLY:	PREMED Y N	ALLERGIES Y N	MEDICATIONS Y N
			DR. INITIAL _____

MEDICAL HISTORY

Statement of Financial Policy

We are committed to provide you the best possible care. If you have dental insurance, we want to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services are due at the time services are rendered. No balances will be billed. We accept cash, checks, Visa, MasterCard, American Express, Discover, and ATM/Debit cards. Payment plans are available upon approval through CareCredit.

Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% per month. **Charges may also be made for broken appointments and appointments cancelled without 48 hours notice.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not involved in that contract.
2. Most insurance payments on claims are based on an arbitrary average of the fees for a particular region and may not reflect the accurate cost of dentistry in this area. Therefore dental services are covered up to the maximum allowance determined by each insurance carrier.
This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. **Not all services are a covered benefit in all contracts.** Some insurance companies arbitrarily select certain services they will not cover.

As dental care providers, our relationship is with you, not your insurance company. **While the filing of insurance is a courtesy that we extend to our patients, ALL charges are your responsibility from the date services are rendered.**

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I HAVE READ AND AGREE TO THE ABOVE TERMS.

Signed _____ Date _____

BEHNER DENTAL PARTNERS

Ronald L. Behner, D.D.S.

Julian W. Behner, D.M.D.

934 E. Altamonte Drive

Altamonte Springs, FL 32701

407-831-5455

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed.

Federal and state laws require us to maintain the privacy of your health information. This notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the change. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations.
For example:

Treatment - We may use your health information for treatment or disclose it to a dentist, specialist, physician, or other health care provider providing treatment to you.

Payment - We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations - We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To Your Family and Friends - We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your healthcare. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location, and general condition. In the event of your incapacity or an emergency we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Appointment Reminders - We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

If you have any questions, please contact us.

Signed _____ Date _____