TIME 01:33 PM DATE 10/18/2023

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Gender: ☐ Male ☐ Female ☐ Unknown Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

HIPAA AUTHORIZED:

HIPAA AUTHORIZED:

HIPAA AUTHORIZED:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

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	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

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

Are you allergic to any of the following?

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

Other? ☐ If yes

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						

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

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:

PALM VALLEY
FAMILY DENTISTRY

Assignment and Release

I, the undersigned, have insurance with _____ and assign directly to Palm Valley Family Dentistry, P.A. all 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 within 30 days from the date of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Financial Agreement

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I acknowledge that all financially responsible parties are to be present for all treatment planning and financial estimates. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. In the event my account balance remains unpaid in excess of 90 days, I understand that my account will be turned over to a collections agency. I accept full responsibility for all administrative and legal fees associated with the collections process.

I understand that Palm Valley Family Dentistry has a broken appointment policy and I will be charged **$40 for hygiene appointments** and **$100 for treatment appointments** unless I notify the office at least 48 hours in advance for a cancelled appointment. We do not accept appointment cancellations left on voicemail or sent via email.

I understand that personal checks are accepted as forms of payment. I also understand that if a check is returned due to insufficient funds, I will be assessed a $50 fee on my account.

_____ _____

Signature Date

PALM VALLEY
FAMILY DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I, the undersigned, acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for the office of Palm Valley Family Dentistry as of today's date.

A copy of the signed, dated acknowledgement shall be as effective as the original.

_____ _____
Signed Date

_____
Printed name

Minor: If you are the legal representative of the patient, please print the patient's name(s) and describe your authority:

_____

_____

I hereby authorize Palm Valley Family dentistry to discuss my dental diagnosis, dental treatment, appointments, and account information with the below named person(s).
****Please be aware that if you do not list anyone in this section, we will be unable to discuss any information pertaining to your records at our office with any other party. ****

_____

_____
If you have any questions about this form, please contact the privacy officer, McKenzie Worten.

Office use only:
As privacy officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgement but did not because:
_____ It was emergency treatment
_____ I could not communicate with the patient
_____ The patient refused to sign
_____ The patient was unable to sign
_____ Other

PALM VALLEY
FAMILY DENTISTRY

Informed Consent for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. By consenting, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you follow your dentist's advice and recommendations regarding medication, pre- and post- treatment instruction, referrals to other dentists or specialists and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. The patient is an important part of the treatment team. In addition, complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition, advise your dentist immediately so that precautions can be taken or your physician consulted, if necessary.

If you are a woman on birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with you physician before relying on oral birth control medication if you dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly know risks and complications of treatment include but are not limited to:

1. Pain, swelling, and discomfort after treatment.
2. Infection and the need for medication, a follow-up procedure, or other treatment.
3. Temporary, or on rare occasions, permanent numbness, pain, tingling, or altered sensation to the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations, or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restoration, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw and jaw related structures requiring follow-up care and treatment or consultation by a dental specialist.
9. Root tip, bone fragment or a piece of a dental instrument may be left in your body and may have to be removed at a later time.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for future treatment.
12. Allergic reaction to anesthetic or medication.
13. Need for follow-up treatment including surgery.

We believe in a complete diagnosis of all conditions in your mouth. All new patients in our office will need radiographs of all areas of the mouth before any services can be provided. If you have recently had x-rays taken at another dental office, please have them emailed or mailed to us. If these x-rays are not current (within 1 year) or are not of diagnostic quality or are not a complete set of x-rays, we will have to take new x-rays before any services can be provided. These new x-rays may not be covered by insurance and will be the patient's financial responsibility. _____ (Please initial.)

This form is intended to provide you with an overview of potential risks and complications. Please discuss the potential benefits, risks and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

_____ _____
Signature Date

_____ _____
Print name Minor's name

PALM VALLEY
FAMILY DENTISTRY

Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We are pleased to use the Oral ID screening device in our office. The Oral ID examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless, and completely safe.

Similar to other cancers, early detection of oral cancer is critical. Studies have shown that early detection of oral cancer with technologies like the Oral ID dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at risk?

- Age 17+
- Tobacco use
- Alcohol use
- HPV infection

If you have any questions about risk factors, please feel free to talk to Dr. Yoder. We recommend all of our patients over 17 be screened with the Oral ID in addition to our routine visual cancer examination.

We feel very strongly that this is an important part of every new patient exam. To make the screening more accessible to our patients, our fee is only $30. If you have insurance, we will gladly file this to your insurance company for you. Coverage on dental insurance plans is increasing, but unfortunately is still not guaranteed. If your insurance does not pay or if you do not have insurance, your fee will be $30.

____ Yes, I request your staff to perform an examination with Oral ID.

Signature:_____ Date: _____

____ No, I prefer not to have this examination at this visit.

Signature: _____ Date: _____

Palm Valley Family Dentistry · 3791 Palm Valley Road, #205 · Ponte Vedra Beach FL · 32082
David Yoder, DDS

PALM VALLEY
FAMILY DENTISTRY

Request to Release Medical Records

I, _____ authorize _____to release copies of my x-rays and any other pertinent information in my file to:

Palm Valley Family Dentistry
3791 Palm Valley Road, #205
Ponte Vedra Beach, FL 32082
P: 904.834.2736 F: 904.834.2737
e: admin@palmvalleyfamilydentistry.com

Patient Signature: _____

Patient Date of Birth: _____

Date: _____