PATIENT INFORMATION

2262 Dunn Ave., Suite 4, Jacksonville, Fl 32218
Phone: (904)696-0000 Fax: (904)696-0060

OFFICE USE ONLY

CHART#_____ BILLING#_____ DATE____/____/____

PLEASE PRINT

PATIENT INFORMATION

Last Name _____ First _____ Middle _____
How would you like to be addressed? _____ **Email-Address:** _____
Home Phone:_____ **Work Phone:** _____ **Mobile:** _____

Mailing Address_____ City_____ State____ Zip_____
How Long _____

Sex M F	Date of Birth Mo. Day Yr.	Marital status S M W D	Social Security				-		-				

Driver's License#_____ State _____ Occupation _____If student, FT/PT? Circle one.
Employer's Name _____ Business Phone _____
Employer's Address _____

PARTY RESPONSIBLE
If other than patient

Last Name _____ First _____ Middle _____
How would you like to be addressed? _____ Home Phone#_____
Mailing Address_____ City_____ State____ Zip_____
How Long _____

Sex M F	Date of Birth Mo. Day Yr.	Marital status S M W D	Social Security				-		-				

Driver's License#_____ State ____ Occupation _____If student, FT/PT? Circle one.
Employer's Name _____ Business Phone _____
Employer's Address_____

DENTAL INSURANCE YES/NO

Insured Party _____Policy# _____ Social Security#_____
Employer _____Phone# _____ Insurance Company_____
Send Claims to _____ Phone# _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO INSURANCE.
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST
ON THE GROUP INSURANCE NENEFITS OTHERWISE PAYABLE TO ME.

_____ _____ _____ _____
SIGNED (PATIENT,OR PARENT IF MINOR) DATE SIGNED (INSURED PERSON) DATE

Previous Dentist's Name_____ Physician's Name_____
Name & Address of Nearest Living Relative _____
In any other member of your family a patient here? Yes No If so, patient's name_____
Whom may we contact in case of an emergency? _____ Phone# _____
What is the one thing about your smile that you would like to change? _____
HOW DID YOU FIND OUT ABOUT OUR OFFICE? (PLEASE CHECK ONE)
1. Referred by a patient, Who? _____ 2. Referred by one of our employees, Who?_____
3. Yellow pages 4. Newspapers 5. Radio 6.TV 7.Direct Mail. What type?_____
8. Brochure 9. Your Employer? 10. Other _____

LISA SALLOUM, D.D.S.

PRACTICE LIMITED TO PERIODONTICS AND IMPLANT DENTISTRY

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? [] Yes [] No

DOCTOR'S NAME	TREATMENT	DATE

2. List all Medications taken in the last six months

_____

_____

_____

3. Are you sensitive or allergic to any medicines? (Penicillin, Aspirin, Codeine, Erythromycin, Iodine, Tetracycline, Epinephrine, Cephalosporins, Clindamycin…) others:
4. Are you sensitive or allergic to any metals? [ ] Yes [ ] No
5. Women; Are you pregnant? [ ] Yes [ ] No
   Do you anticipate becoming pregnant? [ ] Yes [ ] No
   Are you taking birth control pills? [ ] Yes [ ] No
6. Has a physician ever told you that you need to be pre-medicated prior to dental treatment, due to a medical condition? [] Yes [] No

Please circle any of the following conditions which you have been diagnosed with by a physician.

CARDIOVASCULAR (HEART)

1. Heart murmur
2. Rheumatic fever
3. Mitral valve prolapse
4. Artificial heart valve
5. High or low blood pressure
6. Heart failure
7. Heart disease or attack
8. Angina pectoris
9. Heart pacemaker
10. Heart surgery
11. None Know

KIDNEY AND LIVER

1. Liver disease
2. Kidney trouble
3. Excessive bleeding
4. Hepatitis
5. Jaundice
6. GI Disorder

MISCELLANEOUS

1. Artificial joint
2. Cancer or tumor
3. Leukemia
4. Chemotherapy or radiation therapy
5. Anemia
6. Epilepsy or seizures
7. Emphysema
8. Tuberculosis
9. AIDS, HIV, or ARC
10. Diabetes
11. Ulcers
12. Asthma
13. Sinus trouble
14. Thyroid disease
15. Arthritis
16. Psychiatric treatment (ex: depression, anxiety…)
17. Hemophilia
18. Venereal disease (syphilis, gonorrhea, genital herpes)
19. Organ removal or transplant
20. Glaucoma
21. Prostate/Urinary tract
22. Tempromanduliar Dysfunction (TMJ)

To the best of my knowledge all of the preceding answers are true and correct. If I have any changes in my health or medications I will notify my dentist at the next appointment without fail.

_____ _____ _____

Signature of patient, parent or guardian | Date | Signature of DMD or DDS

Medical History Update:

_____ Date:_____ Initials:_____

_____ Date:_____ Initials:_____

PATIENT CONSENT FORM

2262 Dunn Ave., Suite 4, Jacksonville, Fl 32218
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I understand that, under the Health Insurance Probability & Accountability Act of 1996 (HIPAA), 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 prior to signing this consent. I understand that this organization has the right to change it Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand 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 on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

LISA SALLOUM, D.D.S., P.A.

2262 Dunn Ave., Suite 4, Jacksonville, Fl 32218
Phone: (904)696-0000 Fax: (904)696-0060

NAME_____**DATE**_____
(Please print)

FINANCIAL AGREEMENT

NOTE TO PATIENTS WITH DENTAL INSURANCE:

Your dental insurance is your responsibility, but we can help. Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the TOTAL TREATMENT FEE.

As a courtesy to you we do accept assignment of benefit payments from most insurance companies. This will reduce your immediate out-of-pocket expenditures. We allow 30 days for your insurance company to make a payment. AFTER THIS TIME ALL INQUIRIES (FOLLOW-UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

All outstanding balances over 30 days will be charged 1.5% every 30 days.

All balances over 90 days go to collection and their fees are added to the balance.

FINANCIAL AGREEMENT:

I AGREE TO THE FINANCIAL RESPONSIBILITY FOR THE TOTAL FEE. If this is a treatment plan the fees are based on limited information obtained by your insurance company. This treatment plan will be honored for 90 days from the above date. After this time the fees are subject to adjustment.

X_____**DATE:**_____
Patient signature (or parent if patient is a minor)