Dr. Gary S. Padgett

Citrus Care Dental Association, PLLC

514 N.Lecanto Hwy., Citrus Memorial Allen Ridge Healthcare Center, Route 491, Lecanto, FL 34461 Tel: 352-746-3800

Patient Information

Patient Name_______________________________________Account #_____________
First Middle Initial Last (office use only)

Address__________________________ City ________________________________

State____________________________ ZIP___________ Home Phone_____________

Employer Phone ____________________ Birthdate_____________________________

E-mail address _____________________ Social Security Number___________________

Employer Name and Address____

Marital Status: Married Single Divorced Widowed Patient Gender: M F

Spouse ___________________________ Spouse Birth Date _______________________

Spouse Employer ____________________Spouse SSN__________________________

Responsible Party (if different from above)

Name_____________________________ Relationship___________________________

Birth date ___________________________SSN_________________________________

Employer __________________________ Employer Phone________________________

Dental Insurance Information

Policy Holder's Name______________________________ Phone__________________

Social Security Number _____________________________ Birth date ______________

Employer___________________________ Employer Phone________________________

Insurance __________________________ Policy Number_________________________

CITRUS CARE
Dental Association

How did you hear about our office? ____

Reason for today's visit: toothache swelling lost filling accident
dentures routine check up other__________________

Medical Information

Emergency Contact (not living with you)____
Name Phone Relationship

Medications currently taking____

Please read carefully

Citrus Care Dental Association requires payment at time service is rendered. We accept all major credit cards and debit cards. Deferred payment is available through an interest free account with qualified credit. Payment by check is accepted, however in the unlikely event your check is returned, we reserve the right to re-present the item electronically, plus the state allowed processing fee.

I authorize payment of group insurance benefits, otherwise payable to me, directly to Citrus Care Dental Association. My signature is also a file signature for dental insurance. I understand any outstanding balance my insurance does not pay will be my responsibility.
I authorize Citrus Care Dental Association to verify my past and present credit references.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. We are required by federal and state law to maintain the privacy of your health information. We may use or disclose your health information for such reasons listed below: Another health care provider treating you, to obtain payment for services rendered, in connection with our healthcare operations, in reasonably suspected abuse or neglect cases, national security and for appointment reminders. You have the right to access, amend, request a disclosure accounting, and request alternative communications regarding your health information. All must be in writing. You are entitled to receive this notice in written form.

I agree that any dispute about the reasonableness or computation of fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services by any member of Citrus Care Dental Association staff or our doctors, shall be submitted to binding arbitration. It is understood by both doctor and patient that by agreeing to submit all claims or assertions that either patient or doctor may have against the other, arising out of this agreement, all disputes shall be resolved through arbitration.

Citrus Care Dental Association requires advance notice if an appointment has to be cancelled or rescheduled. Please be advised after three missed appointments, Citrus Care Dental Association will not reserve appointments in advance.

Signed____Date___________________________

CITRUS CARE
Dental Association

APPOINTMENTS: WE KEEP SPECIAL OPENINGS FOR **NEW PATIENTS – YOU DO NOT HAVE TO WAIT WEEKS OR EVEN MONTHS TO BE SEEN!**

When you call for an appointment our receptionist will ask certain questions regarding the nature of your problem and dental request in order to allot adequate time for your appointment.

You will also be asked about any previous dental records and x-rays that may be requested by us to eliminate the need for any unnecessary x-rays that may be needed for your appointment.

You will also be asked about any medical conditions such as artificial joints or valves that may require pre medication for your future visit.

You will also be asked about any dental insurance that may be applicable.

Having this information available to us will assist us in scheduling your appointment and allotting adequate time to address your concerns.

INITIAL APPOINTMENT/EXAMINATION

The time during this appointment is used to gather information about your medical and dental history and listen to your concerns and to evaluate your dental condition and problems. It is at this time that we will take any x-rays that are needed to assist us in providing you with a full thorough examination. By gathering all this information we are then able to provide you with your treatment options.

If your dental problems are complex we will frequently schedule a follow up appointment to discuss your options in detail after taking the time to work up several treatment plans for you. You can then choose which option might best suit your situation and needs.

A dental cleaning (prophy) is rarely done at this appointment as we would not know what type of cleaning would be needed in case periodontal disease is involved. In some cases, we can schedule a normal cleaning with our hygienist after your initial examination if enough information can be gathered before the appointment.

EMERGENCY VISITS

We will attempt to work you into our schedule the day you call. This time is devoted to diagnosing the origin of the problem then either perform the procedure to correct the problem or refer you to one of our specialists if necessary and/or prescribe medication to alleviate your symptoms. Frequently this time is spent diagnosing and then explaining options to you.

We are not a dental clinic. We schedule our patients with the appropriate time to treat them as individuals. We do not overbook. Patients are seen by appointment only.

CANCELLATIONS / BROKEN APPOINTMENTS

We value your time and expect the same in return. We do not over book our day. If for some reason you are not able to keep your appointment, we appreciate a 48 hour notice so that we can reappoint that time to another patient’s needs. We reserve the right to charge a fee for missed appointments, if we are not notified based on the time reserved.

CITRUS CARE DENTAL ASSOCIATION

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________________

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

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

☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯	◯	Cortisone Medicine	◯	◯	Hemophilia	◯	◯	Radiation Treatments	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Recent Weight Loss	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Renal Dialysis	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Rheumatic Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Rheumatism	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	High Cholesterol	◯	◯	Scarlet Fever	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hives or Rash	◯	◯	Shingles	◯	◯
Artificial Joint	◯	◯	Excessive Thirst	◯	◯	Hypoglycemia	◯	◯	Sickle Cell Disease	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Irregular Heartbeat	◯	◯	Sinus Trouble	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Kidney Problems	◯	◯	Spina Bifida	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Leukemia	◯	◯	Stomach/Intestinal Disease	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Liver Disease	◯	◯	Stroke	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Low Blood Pressure	◯	◯	Swelling of Limbs	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Lung Disease	◯	◯	Thyroid Disease	◯	◯
Chemotherapy	◯	◯	Hay Fever	◯	◯	Mitral Valve Prolapse	◯	◯	Tonsillitis	◯	◯
Chest Pains	◯	◯	Heart Attack/Failure	◯	◯	Osteoporosis	◯	◯	Tuberculosis	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pacemaker	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
									Yellow Jaundice	◯	◯

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________

Comments: ______________________

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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.

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SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________

Citrus Care Dental Association
Dr. Gary S. Padgett
514 N. Lecanto Hwy., Citrus Memorial Allen Ridge Medical Mall
Lecanto, FL 34461
PHONE: 352-746-3800 FAX: 352-746-3810

AUTHORIZATION TO TRANSFER X-RAYS/RECORDS

Patient: ____

Address: ____

D.O.B.______________________

Authorized release of x-rays/records from Dr. ____________________________________

Address: ____________________________________

____

Phone: ____________________________________

To Authorized Dr. Padgett of Citrus Care Dental Association

Patient permission for x-rays/records:

Signature: ____

I, the patient do not authorize the information to be disclosed or to be used for any other reason other than the above.

(Protected by Federal Confidentiality rules 42 CFR Part 2). Federal rules prohibits further disclosure unless expressly permitted by written consent of the patient to whom it pertains.

FINANCIAL POLICY

Due to the high costs of delivering quality health care we feel a patient should be fully informed of the total costs of their treatment as well as what their insurance benefits are.

Our fees are based on our costs to deliver the quality of care that we are committed to providing our patients with. These costs are the same whether a patient has insurance or not. Our fees are not based on any insurance nor do we have two fee schedules.

We offer the following financial arrangement to our patients.

A) We ask that our patients pay at the time of service in full for procedures up to $1000.00 unless prior arrangements have been made with us.

B) For treatment over $1000.00 that takes multiple appointments, we ask that the patient pay 50% at the start of treatment and the balance prior to completion.

C) For large treatment cases that span over several months we ask that the patient pay 1/3 at the start of treatment, 1/3 at the middle of treatment and the remaining 1/3 at the completion of treatment. These cases are worked out on an individual basis and time frame.

D) We offer a pre payment courtesy (for cases larger than $5,000) of 5% from the total patient obligation (not from any portion due from an insurance company) if paid in full at the start of treatment.

E) You can guarantee your account with a credit card. This way you are giving us permission to bill you for visits in the event we do not receive your payment by the due date.

FORMS OF PAYMENT AND BALANCES DUE

In order to help you facilitate access to the very best health care possible, you may choose from the following options: Cash, Visa, Master card, Discover and American Express, Money Orders and Personal checks.

We also offer the Citi Bank Health Card for cases over $500.00. This card can provide you with interest free money for up to 6 months and low interest money for up to twelve months if approved. We can call and assist you with fast approval at your appointment.

Balances over 60 days in our office will incur a finance charge of 18% APR.

INSURANCE

It is our pleasure to assist you in determining your dental benefits and to assist you in maximizing your insurance during treatment. We will do pre determinations prior to treatment to determine your benefits and will assist you in filing these claims which we do daily electronically in most cases.

Please understand that our obligation is to provide you with the proper treatment that you need and is not influenced by your insurance carrier. Although we will assist you in filing your dental claims, it is important for you to understand that the financial obligation for your dental treatment is between you and our office. The insurance company is responsible to you and not to our office.

We therefore ask that the financial arrangements worked out between you and our office include the total amount and any insurance benefits be directed to you.

Frequently a patient with insurance will see the term “usual and customary”. This fee is not based on information obtained from dental offices but is based on what benefits your employer wishes to purchase for you.

I hereby authorize Dr. Padgett and any associates of Citrus Care Dental Association to release to my insurance company information acquired in the course of my dental care. I understand I am responsible for any and all balances incurred for my dental care.

I understand that my dental treatment can not be completed until it is paid for in full.

I understand that I am responsible for any and all charges associated with this account and that an interest rate of 1.5% per month will accrue on unpaid balances and a statement charge of $5.00 will be added to subsequent statements. Should my account become delinquent, I will assume all additional collection costs and legal fees.

____ Date _________________________

What family members are covered by this agreement: _________________________________

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CONSENT FOR DENTAL TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my child's dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as requited to provide proper care.

I further agree that any dispute about the reasonableness or computation of the fees, or any claim of negligent or intentional acts or omissions in the rendering of professional services, either in this specific instance or in any other treatment rendered, shall be submitted to binding arbitration to the NET-ARBitration. It is understood that all such claims or assertions that either patient or doctor my have against the other arising out of this agreement patient and doctors have given up their right to a jury or a court trial.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only minimum amount of information necessary to provide quality care will be used or disclosed and that a notice outlining the protection of my personal health information is available.

Patient or Parent

Signature: ____

Date

Witness

Signature: ____