HARBOUR
DENTAL CARE

Kevin W. Snyder D.D.S, PA

Today's Date _____/_____/_____

Patient's Name _____
First MI Last

Please let us know if you have a nickname or preferred name by which you wish to be called. _____

Sex ☐ M ☐ F Date of Birth _____/_____/_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address _____
Street City State Zip

Phone # (_____) _____ (_____) _____ (_____) _____
Home # Work # Mobile #

Social Security # _____ **E-mail address** _____
Would you like to receive e-mail confirmations? ☐Yes ☐No

Are you a full time student? ☐ Yes ☐ No If yes, School Name _____

Employer _____
Name Address City State Zip

Has any member of your family been treated in our office? ☐ Yes ☐ No If so, who? _____

Contact in case of emergency _____ (_____) _____
Name Relationship Phone #

☐ Spouse *Or* ☐ Parent if minor _____ (_____) _____
Name Address Phone #

Person Responsible for Account _____
Name Relationship SS#

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's ID # _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Employer _____
Name Address City State Zip

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (_____) _____ Group # _____ Local Union # if any _____

*** I authorize this office to perform diagnostic procedures (examinations, x-rays, study models, and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs. ***

Patient, Parent or Guardian Signature _____ Date _____/_____/_____

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Patient Name: _____ **Date:** _____

HOW DID YOU HEAR ABOUT US? - PLEASE CHECK ALL THAT APPLY

- □ Television
- □ Google Search
- □ Money Pages
- □ Website
- □ Drive By/Sign
- □ Facebook
- □ Billboard
- □ Insurance
- □ Jacksonville Magazine
- □ Patient Referral _____
- □ Specialist Referral _____

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Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Any changes in Phone #'s:_____

Are you under a physician's care now? ☐ Yes ☐ No If so, for what? _____

_____

Physician's Name _____ Phone # (_____) _____

Are you taking any medications, vitamins or herbal supplements? ☐ Yes ☐ No Please list below

_____
_____
_____
_____
_____
_____
_____
_____

Are you pregnant? ☐ Yes ☐ No If yes, due date _____

Are you on a special diet? ☐ Yes ☐ No

Any digestive problems? ☐ Yes ☐ No

Do you use tobacco in any form? ☐ Yes ☐ No _____

Have you ever taken or are you currently taking any bisphosphonates such as Zometa, Fosamax, Aredia, Actonel, Boniva Didronel, Skelid, Bonefos, or alendronate? ☐ Yes ☐ No

Are you allergic to any medications or substances? ☐ Yes ☐ No If yes, please check boxes below.

☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine
☐ Latex or Rubber ☐ Other _____

Have you ever had a reaction or experienced complications to any dental treatment in the past? ☐ Yes ☐ No

Please check "yes" if you presently have or have had in the past any of the following conditions:

	Yes		Yes		Yes
Heart Trouble/Disease	☐	Lung or Breathing Problems	☐	Severe Headaches	☐
Heart Murmur*	☐	Shortness of Breath	☐	Fainting or Dizzy Spells	☐
Irregular Heart Beat	☐	Sinus Trouble	☐	Epilepsy, Seizures or Convulsions	☐
Angina or Chest Pain	☐	Asthma	☐	Psychiatric Care	☐
Heart Attack or Failure	☐	Chronic Cough	☐	Hepatitis, Jaundice or Liver disease	☐
Congenital Heart Disorder	☐	Emphysema	☐	Arthritis, Gout or Rheumatism	☐
Mitral Valve Prolapse*	☐	Tuberculosis (TB)	☐	Artificial Joint*	☐
Rheumatic Fever*	☐	Frequent Sore Throat	☐	Night Sweats	☐
Artificial Heart Valve*	☐	Tumor or Cancer	☐	Stomach or Intestinal Disease	☐
Heart Pacemaker*	☐	X-ray or Cobalt Treatment	☐	Thyroid Disease	☐
Heart Surgery	☐	Chemotherapy	☐	Kidney or Bladder Problems	☐
Stroke	☐	Enlarged Lymph Nodes (Glands)	☐	Renal Dialysis	☐
Aneurysm	☐	Swelling of Limbs	☐	Hypoglycemia	☐
High Blood Pressure	☐	Bruise Easily	☐	Frequent Diarrhea	☐
Low Blood Pressure	☐	HIV Positive or AIDS	☐	Glaucoma or Eye Problems	☐
Bleeding Disorder	☐	Sexually Transmitted Diseases	☐	Excessive Thirst	☐
Blood Transfusion	☐	Major surgery	☐	Diabetes	☐

Have you ever had any other disease, problem or condition not listed above? ☐ Yes ☐ No Discuss _____

_____

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature _____ Date _____

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Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Date and reason for last dental visit_____

When were your last dental x-rays taken?_____

Name of previous dentist _____

Do you have any current concerns? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____

APPREHENSION

Have you ever experienced complications with any dental treatment? ☐ Yes ☐ No

Do you feel you need any help overcoming fear of having dental treatment? ☐ Yes ☐ No

Have you ever received laughing gas or nitrous during a dental visit? ☐ Yes ☐ No

Would you like to have it here in this office? ☐ Yes ☐ No

Have you received any other kind of sedation for dental treatment? (IV sedation, Valium, or other medications?) ☐ Yes ☐ No
If yes, please list: _____

PERIODONTAL HEALTH

Have you ever been treated for periodontal disease? ☐ Yes ☐ No

Do your gums ever bleed when you brush or floss? ☐ Yes ☐ No

Are your gums red, swollen or tender? ☐ Yes ☐ No

Do you have any area that is hard to floss? ☐ Yes ☐ No

Does food tend to wedge between any of your teeth? ☐ Yes ☐ No

Do you notice recession on any of your teeth? ☐ Yes ☐ No

Have any of your teeth drifted, separated or become loose? ☐ Yes ☐ No

Did either of your parents lose their teeth due to gum disease? ☐ Yes ☐ No

OCCLUSION AND TMJ

Do you ever have headaches? ☐ Yes ☐ No

Have you ever had an injury to your face, head or neck? ☐ Yes ☐ No

Does your jaw ever pop or crack? ☐ Yes ☐ No

Do your jaw or facial muscles ever get tired or sore? ☐ Yes ☐ No

If so, when do you notice it?_____

Have you ever worn a nightguard? ☐ Yes ☐ No

EXISTING CONDITIONS

Do you have any missing teeth? ☐ Yes ☐ No
If so, how long have they been missing? _____

Do you wear a partial denture or full denture? ☐ Yes ☐ No

Do you experience any of the following? (Check all that apply)

- ☐ Dry mouth
- ☐ Bad breath
- ☐ Unusual taste in your mouth
- ☐ Sensitivity to hot or cold
- ☐ Pain when eating sweets
- ☐ Pain when biting down

Are there any areas of your mouth that you can't or don't like to chew on? ☐ Yes ☐ No

COSMETICS

If you could change anything about your smile, what would it be?
_____
_____

Have you ever worn braces or received any orthodontic treatment? ☐ Yes ☐ No

Would you be interested in whitening your teeth? ☐ Yes ☐ No

NUTRITION AND HEALTH

How much water do you drink per day? _____

How much soda do you drink per day? _____

Do you snack frequently? ☐ Yes ☐ No

Do you smoke cigarettes, cigars, e-cigarettes, etc.? ☐ Yes ☐ No
If so, how often? _____

OTHER?

☐ Yes ☐ No
If yes, please describe:
_____
_____
_____

HARBOUR
DENTAL CARE

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We are pleased you chose Harbour Dental Care to facilitate and care for your dental health needs. In order for us to keep costs as low as possible, we require that payment is made at time of service. The following is a statement of our financial policy, which we require you read and agree to prior to treatment.

Payment Options

1. We accept Cash, Checks, Master Card, Visa, and Debit cards.
2. We offer extended Payment plans with no interest through Care Credit to those who qualify. Care Credit offers flexibility for those who prefer low monthly payments.
3. Other financial arrangements are reserved for cases over $2,000. We are happy to discuss these options with you if the situation applies.

Insurance:

For those patients who have financial assistance from insurance, your estimated co-insurance amount is due at this time. We will submit dental claims for you; however, your insurance is a contract between you, your employer, and the insurance company. As your dental provider our relationship is with you, not the insurance company.

All charges incurred are the responsibility of the patient regardless of your insurance coverage. We will cooperate fully with the regulations and requests of your insurance company that may assist in your claim being paid. Disputes or denied claims should be directed to your insurance carrier and/or employer.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received within 60 days from the date of filing, or your claim is denied, you will be responsible for paying the full balance. If a claim is denied, we will make every effort to appeal and send further documentation to support the claim. If we receive any payment from your insurance company and you have paid your bill in full, we will remit the payment directly to you.

Minors of Separated or Divorced Parents:

When two parents are each responsible for portions of a child's dental care, ***the Parent or Guardian who brings the child is responsible*** for co-insurance and full fee at date of service. They are also responsible for collecting payment from the other parent. Prearrangements must be made with our office if another party will be bringing the child for his appointment.

Returned Checks/ NSF:

A $30.00 fee will be assessed for all returned or NSF checks and we reserve the right to reject future check payments.

Short Notice Cancellations and Broken Appointments:

We require *2 business days notice* for any cancellations or changes to scheduled appointments. At our discretion, broken appointments and short notice cancellations may be charged a fee of $50 per scheduled hour. We reserve the right to decline future appointments to patients with an outstanding balance. In rare circumstances, we may also require your next visit be secured with a credit card deposit.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized. We pride ourselves on being available to provide treatment in a timely manner and to relieve those who are having tooth pain as fast as possible.

I have read and understand the financial policies of Dr. Kevin Snyder and Harbour Dental Care. I understand I am responsible for all fees incurred for my dental treatment.

_____Patient initials

I understand insurance plans are payment assistance programs; they are not designed to cover the entire cost of treatment. I understand my insurance carrier may pay less than the actual bill for services. By signing this form I have authorized assignment of benefits directly to Dr. Kevin Snyder and this practice.

_____ Patient initials

I understand I am responsible for any and all charges that may occur if my account is turned over for collections.

_____ Patient initials

*Signed*_____ *Date:* ____/____/_____
Patient or Guardian Signature

Print Patient's Name: _____

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only ___ Proper Sir Name ___ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:**

Cell Phone Confirmation ____
Home Phone Confirmation ____
Work Phone Confirmation ____

Text Message to my Cell Phone
( ) _____ - _____

Email Confirmation ____ _____ (Email address)
Any of the Above ___

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

Cell Phone Message ___
Home Phone Message ___
Work Phone Message ___

Text Message ___
Email Message ___
Any of the Above ___

Dr. Snyder and Harbour Dental Care wants to keep our patients informed by sharing dental health information to promote improved health, as well as promotions, specials, services, practice updates, and special events. In signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize, that this office may communicate with you. This office may not receive third party remuneration from affiliated companies nor will your information be shared or sold. If you choose to opt out or limit communication, you may log in to your patient portal and customize communication settings.
We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for this healthcare facility. A copy of the signed, dated document shall be as effective as the original.

_____/_____/_____
Today's Date – D/M/Y

_____ _____
Name of Patient (Print) Patient or Guardian Signature

_____ _____
Legal Representative/Guardian Relationship of Legal Representative or Guardian

Your comments regarding acknowledgements or Consents:
_____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was an emergency _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer