DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS
List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance 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. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below:

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

STATE OF FLORIDA
DEPARTMENT OF HEALTH
NON-COVERED SERVICES FORM

Non-Covered Services | Private Pay Member Commitment Form

BEACON SQUARE FAMILY DENTISTRY **PROVIDER: DR. SHAPIRO**

561.998.0901 **DATE OF TREATMENT PLAN:** _____

BEACON SQUARE FAMILY DENTISTRY HAS ADVISED ME THAT THERE MAY OR MAY NOT BE COVERED SERVICES TO TAKE CARE OF SOME OF MY DENTAL CONCERNS BECAUSE OF THE FOLLOWING:

1. My insurance company routinely downgrades my child's resin composite filling to amalgam restorations containing mercury;
2. My insurance company routinely bundles necessary x-rays into a full mouth series which can be as old as 3 years and is no longer diagnostic to my child's needs;
3. My insurance company routinely disallows cavity finding x-rays which are deemed necessary by Dr. Shapiro;
4. My insurance company routinely denies debridement / deep cleanings, medications and rinses;
5. My insurance company does not provide orthodontic coverage unless my child's condition creates a disability and an impairment to their physical development.

AFTER MY EXAMINATION, A TREATMENT PLAN WILL BE EXPLAINED TO ME WHICH WILL ESTIMATE WHAT MY INSURANCE SHOULD PAY AND WHAT MY COPAYMENT WILL BE AT TIME OF TREATMENT, AND I AGREE TO PAY FOR ANY DENTAL SERVICES PROVIDED BY DR. SHAPIRO THAT MY INSURANCE COMPANY FAILS TO PAY.

_____ _____ _____ _____
Patient / Guardian Signature Date Print Name Relationship to Patient

_____
Treatment Plan Presenter

BEACON SQUARE FAMILY DENTISTRY
7805 N.W. BEACON SQUARE BLVD., SUITE 101, BOCA RATON, FL 33487
561.998.0901

DENTAL INSURANCE

Beacon Square Family Dentistry practices quality dentistry. We will treat you as we would treat ourselves. We will provide you with a plan of treatment prior to your procedures, and will make every reasonable attempt to estimate your copayment. Unfortunately, this is only an estimate and you must be aware of the following:

1. Most insurance plans have deductibles;
2. There may be contractual changes between the insurance company and your employer;
3. Your insurance company may not pay for the best treatment; for instance they may pay for metal crowns and not porcelain crowns on your back teeth, and they will not pay to replace teeth missing prior to coverage;
4. Some insurance companies pay for 2 cleanings a year, others 1 cleaning every 6 months and a day;
5. Although it has been shown that the mercury in silver has been classified as potentially dangerous, some insurance companies will pay for only mercury fillings on back teeth. **We feel this is wrong and may affect our patient's health and therefore do not place mercury fillings;**
6. Some insurance plans have waiting periods (some up to 2 years) before they will pay for anything but a simple cleaning;
7. Some insurance representatives fail to provide the correct information, others refuse to fax benefits or coverage verification to our office for our records and most refuse to tell us when your last treatment at another dental office occurred;
8. Although x-rays are diagnostic and necessary and payable at 100% with no deductible by some insurance companies, the same company will not pay 100% and apply a deductible.

We hear time and time again: "My insurance pays for everything." This is not true. And we did not choose your insurance company, nor are we employees of your insurance company. This office will submit your claim as a courtesy to you. We will send necessary documentation and x-rays when requested. If your insurance company fails to pay your claim within (30) days, you will be responsible for payment in full. Please remember your insurance company is a business and wants to make a profit.

I have read and understand the above and acknowledge responsibility of payment should my insurance company fail to pay my claim for any reason.

_____ _____
Patient / Guardian Signature Date

_____ _____
Print Name Relationship to Patient

REGISTRATION AND TREATMENT

Date _____ Home Phone (____) _____

Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐M ☐F Age ____ Birthdate _____ ☐Married ☐Widowed ☐Single ☐Minor

Home Phone _____ Cell _____ ☐Separated ☐Divorced ☐Partnered for ____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

☐I authorize this office to contact me ☐Phone ☐Cell ☐Email ☐Text ☐Mail

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ ID # / Soc. Sec. # _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please Complete Above Information and Other Side

Submit this Form Print