Skylight
Dental Care

Patient Registration Form:

Patient Information/Información del Paciente: Date/Fecha: _____

(Last Name, First Name and Middle Initial / Apellido, Nombre) (Date of Birth/ Fecha de Nacimiento)

SS# / Numero de Seguro Social E-Mail / Correo Electrónico

Address/ Dirección City/Ciudad State/Estado Zip/Código Postal

Phone Number / Numero de Teléfono Alternate Phone Number/ Numero Secundario EXT.

Emergency Contact:

(Last, First and Middle Initial / Apellido, Nombre) Phone Number / Numero de Teléfono

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Responsible Party Information (If other than the patient) / **Información de la Persona Responsable por el Paciente** (Solo necesario llenar esta sección si usted no es el paciente) :

(Last Name, First Name and Middle Initial / Apellido, Nombre) (Date of Birth/ Fecha de Nacimiento)

Relationship to Patient / Relación con el Paciente E-Mail / Correo Electrónico

Address/ Dirección City/Ciudad State/Estado Zip/Código Postal

Phone Number / Numero de Teléfono Alternate Phone Number/ Numero Secundario EXT.

Insurance Information/ Información de Seguro:

☐ Self Pay/ No tengo Seguro ☐ Medicaid/Seguro dental proveído por el Gobierno ☐ PPO Insurance/ Seguro PPO

Insurance Company / Nombre de Seguro Dental Subscriber Id/ Numero de Miembro SS# / Numero de Seguro Social

Employer / Empleador Group # / Numero de Group Ins. Phone # / Teléfono de Seguro

(Subscriber Last, First and Middle Initial / Apellido y Nombre del encargado del Seguro) (Subscriber Date of Birth/ Fecha de Nacimiento del encargado de Seguro)

Skylight Dental Care
117 N. Oakwood Avenue
Brandon, FL 33510
813-530-0991

CONSENT FOR TREATMENT OF A MINOR WITHOUT PARENT BEING PRESENT

I, _____, give Skylight Dental Care permission to treat my child, _____, while I am not present in the office. The individual bringing my child to the appointment is, _____, and is at least eighteen years of age and is the patient's _____.

I also give this Individual permission to make decisions regarding my child's dental treatment: I understand payment is expected at the time of treatment. Please also note that children of the age 3 and up are to go to the back for x-rays, cleanings, exams and treatment by themselves, with the exception of certain circumstances, these will be determined by the office manager and the Doctor.

Parental contact information for questions regarding treatment and/or questions related to the minor:

Parent/Guardian Information:

Name:_____ Email: _____

Cell: _____ Home: _____ Work: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Signed: _____Date: _____

Relationship to Patient:

_____

PLEASE ATTACH COPY OF GOVERNMENT ISSUED ID

OUR FINANCIAL POLICY

Thank you for choosing Skylight Dental Care as your dental care provider. Please thoroughly read and sign our policy agreement.
Payment is due in ***full*** at the time services are rendered to you as well as any individual for whom you are financially responsible for. Payments can be made via cash, check, credit cards, and money orders. There is also the option for flexible financing, with approved credit.
We cannot bill your insurance company unless you have provided us with your complete and accurate dental insurance information. As a courtesy, we will attempt to verify your policy. Your insurance policy is a contract between you and your insurance carrier. Please make yourself aware of what your insurance plan consists of; this includes your yearly maximums and deductibles. Also, be aware that some, and perhaps all, of the services provided may be considered "non-covered" services and/or not considered reasonable and necessary under your dental insurance. Again, all co-pays and deductibles are due at time services are rendered.
Insurances are filed when a social security number is provided, if you choose to not provide us with your social security number, you will be responsible for the full payment of services rendered. We require social security numbers as well as a valid government issued picture identification. They are for proper record keeping, and you will not be seen if you do not have a valid form of identification.
Although treatment plans are given with an ***estimated*** patient balance on the date of service, it may differ from what the insurance carrier will ultimately pay. You, the responsible party, are responsible for any amount not paid by the insurance for any reason. You may receive a statement/invoice reflecting the balance due which will be due immediately upon receipt. In addition, maximum service charges will be charged in the event that a payment made via check, electronic authorization or debit is returned.
In the event that you choose to discontinue treatment, including but not limited to, partials, dentures, crowns, bridgework and surgical preparatory work, you will remain responsible for paying all lab related costs.
All accounts not paid upon becoming due will result in you, the responsible party, being sent to collections, which in turn results in being reported to credit bureaus, collection agency fees, reasonable attorney fees, and court costs.
In the event that your records are needed and are not sent directly to another provider, there will be a charge of $15.00 for copies of x-rays, and if treatment information is needed there will be an additional $5.00 fee, or the maximum amount allowed by law or your insurance carrier. Fees are subject to change without notice.
MISSED APPOINTMENTS
Appointment times are reserved especially for you and for whom you are financially responsible for. If you are more than 15 minutes late, for any reason, you may be requested to reschedule your reservation and be charged the ***$75.00*** (based on insurance guidelines) missed appointment fee. This fee will also be charged if you fail to show to an appointment. Skylight Dental Care **requires at least 24 hours notice** if you need to cancel or reschedule your reserved time. Due to high request volume, any failed afternoon appointments may result in loss of privilege to schedule at these times.
I have thoroughly read, understand and agree to the above terms and conditions.

_____ _____

Printed Name Patient Name (if guardian is signing)

_____ _____

Signature of Patient (or authorized guardian) Date

_____

Relationship to patient

117 N. Oakwood Avenue
Brandon, FL 33510
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Patient Acknowledgement
Receipt of Privacy Notice

I, hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Skylight Dental Care . Under federal law 104-191, also known as HIPPA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name:

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

Privacy HIPAA Consent Form

I _____, give _____ permission

(Name of Patient) (Name of Authorized Individual)

to discuss any appointments and/or treatment related to my care as well as pick up any documents/cases on my behalf. This consent will be valid as of _____ unless revoked in writing to Skylight Dental Care, or myself. (Date)

_____ _____

Signature Date

_____

Printed Name

Eaglesoft Medical History(Copy)

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, 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
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	

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
☐ NO ALLERGIES

Do you use controlled substances?	○ Yes ○ No	If yes
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	Autism ○ Yes ○ No	ADD/ADHD ○ 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:_____

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising*

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:
◯ *"Yes, I would like a copy of this form."*
(initialed by team member, copy provided by _____)

Practice Name: _____

Patient Name: _____

Date: _____

Signature: _____

If Personal Representative

Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

If Patient is a Minor

Parent / Legal Guardian: _____

Date: _____

Signature: _____

Form provided courtesy of:
MySocialPractice

This form is provided by My Social Practice for general convenience purposes and does not represent legal advice. Additional compliance rules vary from state to state, country to country. If you feel like you need legal consultation in addition to what we've provided, be sure to consult your practice attorney including seeking advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services regulations. My Social Practice is a social media marketing company. We are NOT attorneys, and although this form is based on our own research to ensure compliance, it does not represent legal advice.

You may download this form as a PDF, at no charge, for printing yourself at: MySocialPractice.com/hipaaform

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising*

Revocability:
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◯ *"Yes, I would like a copy of this form."*
(initialed by team member, copy provided by)

Practice Name: _____

Patient Name: _____

Date: _____

Signature: _____

If Personal Representative

Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

If Patient is a Minor

Parent / Legal Guardian: _____

Date: _____

Signature: _____

Form provided courtesy of:
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You may download this form as a PDF, at no charge, for printing yourself at: MySocialPractice.com/hipaaform