MAI DENTISTRY
OF LAND O' LAKES

2624 Stonewood Park Loop
Land O' Lakes, FL 34638
(813)590-2624
www.maidentistrylol.com
frontdesk-lol@maidentistry.com

Welcome to our Practice

We invite you to be a part of our caring dental family. Our mission is to help you obtain the beautiful and healthy smile you deserve. We are committed to gentle, comfortable, and comprehensive dental care for patients of all ages. We strive to become your trusted family dental practice by providing you with personalized treatments far exceeding your expectations.

Patient Name: ______________________________ __________________________ ____ _____________________
Last First M Preferred Name

Date of Birth: ___/___/______ Gender: ○ Male ○ Female Family Status: ○ Single ○ Married ○ Other ○ Child

SS#: _____-_____-________ Email Address: ____
Phone: ________________________________ ______________________________ ___________________________
Home Cell Work
Address: ____ __________________________________
____________________________________ _________ ___________________ Best time to call: ___________

Please list current occupation: ____

Whom may we thank for referring you to our practice? ____

In an emergency who should be notified? Please enter Name and Phone number below:
____

Primary Dental Insurance:

If you have insurance please tell us the name of the company, the phone number to reach them, your identification number, and group number. If you are not the insured, please also list that persons first and last name and date of birth. If none type N/A. *
____
____
____

Insurance Authorization:

I authorize my insurance to pay my benefits directly to the dentist for all services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether paid by insurance.

Signature: ____ Date ________________________________

Medical History

Indicate which of the following you have had or have at present. By checking the box, it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ Pre-Med - Amox	☐ Pre-Med - Clind	☐ Pre-Med - Other	☐ Aids/HIV
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Latex
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Anemia	☐ Arthritis
☐ Artificial Heart Valv	☐ Artificial Joints	☐ Asthma	☐ Back/Neck Problems
☐ Blood Disease	☐ Blood Thinner	☐ Cancer	☐ Chemical Dependency
☐ Chemotherapy	☐ Circulatory Problems	☐ Cortisone Treatment	☐ Diabetes
☐ Dizziness/Fainting	☐ Epilepsy	☐ Excessive Bleeding	☐ Glaucoma
☐ Head Injuries	☐ Headaches	☐ Heart Disease	☐ Heart Murmur
☐ Hemophilia	☐ Hepatitis	☐ Herpes	☐ High Blood Pressure
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Med Hist/Med List Given	☐ Mental Disorders	☐ Mental Illness	☐ MitralValve Prolapse
☐ Nervous Disorders	☐ Other Heat Problems	☐ Pacemaker	☐ Persistent Cough
☐ Pregnancy (currently)	☐ Prosthesis/Pins/ Rods	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

☐ Ever been hospitalized (illness or injury)	☐ Presently being treated for any other illnesses
☐ Subject to frequent headaches	☐ Tobacco/Alcohol Use
☐ FEMALE: Taking birth control pills	☐ FEMALE: Currently Pregnant

If any condition or alerts selected above needs further clarification, please explain below:

____

____

____

Are you on any blood thinners e.g. aspirin, warfarin, coumadin, heparin..ect.? YES or NO

Any bone or muscle conditions? YES or NO
If yes, please explain: ____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

____

Any OTHER conditions not mentioned? If so, please explain

____

____

Name of physician and their specialty and phone number (if you do not have one please write "none"):

____

____

Have you had any serious illness or operations?

____

____

List all medications, supplements, and/or vitamins being taken, if none write "none" or "N/A":

____

____

____

____

List all allergies, if none write "none" or "N/A":

____

____

____

By providing a signature, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are NO OTHER medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any and all future changes.

Signature ____ Date _______________________

Dental Information

How would you rate the condition of your mouth? Circle one: Excellent Good Fair Poor

Would you like a brighter smile? Circle one: Yes No Indifferent

Do you like the shape and size of your teeth? Circle one: Yes No Indifferent

Are you concerned about wear or chipping on your front teeth? Circle one: Yes No Indifferent

Do you have missing teeth you would like to replace? Circle one: Yes No Indifferent

Previous Dentist name and phone number: ____

I routinely see my dentist every: Circle one: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

What is your immediate concern? ____

Is there anything about the appearance of your smile that you would like to change?

____

Personal History, check all that apply:

- ☐ Had an unfavorable dental experience
- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitivity to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint/pain
- ☐ You have difficult chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed and unpleasant taste or odor in your mouth/bad breath
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Have any blisters, sores, or growths
- ☐ Have broken fillings
- ☐ You bite your fingernails

On a scale of 1-10 how fearful are you of the dentist? ______________

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon payment and/or reimbursement from patients for the costs incurred in their care. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. If your insurance company has not paid your account within 90 days, we will request payment to settle your account. As such you agree as follows: In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing within the time payment is due. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any future term or condition and I further agree to pay all costs and reasonable attorney fees if a collection suit be instituted here under. I also understand that failure to provide 24 hours' notice when rescheduling or canceling appointments will result in a minimum $40.00 charge or up to 25% of the scheduled treatment. I further understand that x-rays are property of Mai Dentistry and I must give written notice to request them to be duplicated.
By providing a signature, I understand the above information and agree with its contents.

Signature____ Date ___________________________

Notice of Privacy Practices Acknowledgment

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: 1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment 2. Obtaining payment from third party payers (e.g. my insurance company); 3. The day to day healthcare operations of your practice. I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

To whom may we release information about your dental treatment/record to? Please state the name and relationship or if there is nobody please indicate that below:

____

____

Unless otherwise revoked, I understand this authorization expires six (6) years from the date of signature. By providing a signature, I understand the above information and agree with its contents for the HIPAA Disclosure form.

Signature ____ Date____________________

Consent for Internet Communications

Our office would like to communicate with you electronically via email and sms. By utilizing our practice's electronic services, you agree that Mai Dentistry may communicate with you regarding any information to the email and cell phone number you give us. I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warranty that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information and use their best efforts to maintain persons or entities under their direction or control to comply with such laws. I understand the dental practice will use commercially reasonable efforts to maintain confidentiality of all patient information that is used with any electronic services. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THESE SERVICE.

I have read the information above and grant the dental practice permission to contact me electronically.

Signature ____ Date _____________________________

Photo Release

I hereby authorize Mai Dentistry of St. Petersburg permission to use my likeness in any and all of its publications. I understand and agree that any photographs using my likeness will become property of Mai Dentistry. I acknowledge that since my participation with Mai Dentistry is voluntary, I will receive no financial compensation. I hereby authorize Mai Dentistry to edit, alter, exhibit, publish, or distribute this or these photo(s). In addition, I waive my right to inspect or approve the finished photo, including written or electronic copy. Additionally, I waive the right to any royalties, or any other compensation arising or related to the use of the photo(s).

I am at least 18 years of age and competent to consent in my own name. I have read this release before signing and fully understand the contents, meaning, and impact of this release.

Signature ____ Date _________________________

Top of Form