

Joshua M. Ferraro D.D.S.
1708 South Alexander
Street Plant City, FL 33563
813-752-5600

Welcome to Our Practice!

On behalf of my team, I want to welcome you to our office. We are pleased that you have selected us to care for your dental needs, and we look forward to your initial visit.

We want you to know that we are committed to provide you with the highest quality of oral health care, in the most gentle and efficient manner possible. We pride ourselves on making dentistry a pleasant experience for you, while providing you with the best dental treatment.

Our practice is prevention-oriented, and your first visit with us will include a comprehensive examination and all x-rays needed to diagnose the condition of your mouth. In most instances, your diagnosis will be determined at this visit, and, if needed, recommendations for treatment will be discussed with you.

Your time is important to us, and, except for emergency situations, you can expect us to be on time for your appointment. We appreciate the same from our patients, and expect at least 24 hours' notice for appointment cancellation, which will allow us to schedule your reserved time to another patient in need.

We have enclosed the forms that will be needed for your first visit. Please review and bring the completed forms to your appointment. For your convenience, we have included an appointment card in this packet.

If you have dental benefits, please bring your card and benefit information, so we may file to your **PPO** insurance company. Please do not hesitate to call us prior to your appointment if you have any questions. Again, thank you for choosing our office. We look forward to a lifetime of continuing care.

Joshua M. Ferraro D.D.S.

Patient Registration

Information will be held in the strictest of confidence.

Patient Name	Date
Address	Preferred Name
City, State, Zip	S.S.
Male ☐ Female ☐ Single ☐ Married ☐ Minor ☐ Widow ☐	D.O.B. Age
Employer/School	Home Phone
Address	Work Phone
City, State, Zip	Cell Phone
Occupation	E-Mail
Referred by:	Notes:

Person responsible for account:	Relation:
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<u>Your Spouse</u>	<u>Dental Insurance</u>
Name	Policy Holder
D.O.B.	Relation to Patient
S.S.	Insurance Co.
Employer	Group# ID#
Work Phone	Phone
<u>Emergency Contact</u>	<u>Secondary Insurance</u>
Name	Policy Holder
Relationship	Insurance Co.
Phone 1:	Group# ID#
Phone 2:	Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Kelley L. Borders D.M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Joshua M. Ferraro D.D.S

Medical and Dental History

Name: _____ DOB: _____ Today's Date: _____

Are you under a physician's care now? Yes No Doctor's Name: _____

Phone: _____

Have you ever been hospitalized? Yes No Reason: _____

Have you had a major operation? Yes No What Type: _____

Have you had a serious head or neck injury? Yes No When: _____

Are you taking any medications, pills, or drugs? Yes No: If yes, please list the medications, pills, or drugs:

Have you ever taken Phen-Fen or Redux? Yes No When: _____

Have you ever taken bisphosphonates? Yes No When: _____
(Fosamax, Boniva, Actonel, Zometa)

Are you on a special diet? Yes No Reason: _____

Do you use tobacco? Yes No Type/Amount: _____

Do you use controlled substances? Yes No Type/Amount: _____

Dental History

Are you happy with your past dental visits? Yes No If no, Why? _____

Do you have any fear of dental work? Yes No Please Circle: Slight Moderate Severe

Do your gums bleed when brushing or flossing? Yes No

Do you feel you have bad breath? Yes No

Would you like your teeth to be whiter? Yes No

Do you have trouble opening or closing your jaw? Yes No Please Circle: Opening Closing

Would you like to improve your smile? Yes No If yes, How? _____

Have you ever had braces? Yes No

When was your last dental cleaning? _____

Have you ever had a reaction to any dental anesthetic? Yes No If yes, What? _____

How did you hear about our office? (Please Circle)

Online Search

Website / Insurance

Walk-in/Drive By

Friend / Family: _____ Other: _____

Joshua M. Ferraro D.D.S.

Medical and Dental History

Medical History

(Women Only) Are you Pregnant/Trying to get Pregnant? ____ Nursing? ____ Taking oral contraceptives? ____

Circle if you are **Allergic** to any of the following:

Aspirin	Penicillin/Amoxicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Please List any other Allergies: _____

Circle if you have any of the following **Medical Concerns**:

AIDS/HIV positive	Hepatitis A	Hepatitis B or C	Drug Addiction
Herpes/Cold Sores	Diabetes	Excessive Thirst	Swelling of Limbs
Shingles	Recent Weight Loss	Sinus Troubles	Frequent Cough
Breathing Problems	Easily Winded	Asthma	Anemia
Excessive Bleeding	Blood Transfusion	Emphysema	Lung Disease
Thyroid Disease	Parathyroid Disease	Liver Disease	Stomach Disease
Sickle Cell Disease	Alzheimer's Disease	High Blood Pressure	Low Blood Pressure
High Cholesterol	Scarlet Fever	Hypoglycemia	Hemophilia
Renal Dialysis	Anaphylaxis	Epilepsy or Seizures	Angina
Rheumatic Fever	Rheumatism	Tuberculosis	Yellow Jaundice
Kidney Problems	Osteoporosis	Artificial Heart Valve	Mitral Valve Prolapse
Tumor or Growths	Congenital Heart Disorder	Heart Murmur	Heart Pacemaker
Heart Attack/Failure	Irregular Heartbeat	Leukemia	Cancer
Radiation Treatments	Chemotherapy	Fainting Spells/Dizziness	Stroke
Psychiatric Care	Bruise Easily	Glaucoma	Frequent Headaches
Arthritis/Gout	Chest Pains		

Do you have a medical concern not listed? Please explain: _____

Additional 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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X _____

Date: _____

Joshua M. Ferraro D.D.S.

**HIPAA AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION
("Authorization")**

By signing this Authorization, you agree to the release of your Protected Health Information¹ as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA² Privacy Rule.³ If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

Our Dental Practice contact information:

Dental Practice Name:	Joshua M. Ferraro DDS
Privacy Official for Dental Practice:	Joshua M. Ferraro DDS
Dental Practice mailing address:	1708 S. Alexander St. Plant City, FL 33563
Dental Practice email address:	office@bordersdental.com
Dental Practice phone number:	813-752-5600

Your contact information (please complete):

Patient name	
Patient mailing address	
Patient email address (Optional)	
Patient phone number	

Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):

I authorize the Dental Practice named above to release the following Protected Health Information:

___ Dental image(s)

¹ "Protected Health Information" is information (i) about your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies you directly or indirectly (*i.e.*, there is a reasonable basis to believe that the information could be used to identify you); and (iii) that is maintained or transmitted by the Health Plan.

² "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.

³ The "Privacy Rule" refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA.

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

Patient Signature

Date

OR

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐

Other: _____

Joshua M. Ferraro D.D.S.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Joshua M. Ferraro DDS

*** You May Refuse to Sign This Acknowledgment***

I have read or received a copy upon request of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

PLEASE LIST ANYONE WE MAY DISCLOSE YOUR PERSONAL HEALTH INFORMATION

_____ Relationship: _____

_____ Relationship: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Dr. Joshua M. Ferraro
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24 HOUR APPOINTMENT CANCELLATION POLICY

Joshua M. Ferraro D.D.S. has a 24-hour cancellation/rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged \$25.

Cancellations with less than 24 hours' notice are difficult to fill. This office is a private practice dental office, and your appointment time is reserved for your treatment. If you do not provide adequate notice, you are preventing another patient from receiving care during your appointed time.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Joshua M. Ferraro D.D.S., as described above.

Thank you for your understanding and cooperation.

Printed Name

Signature

Date

Email and Text Messaging Program Patient Information Form

We provide our patients the option to participate in our online patient communication system.

Some of the system features allow you the ability to:

- Request Appointments via Email
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Customer Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email, or by replying to a text message with 'STOP'. Standard text messaging rates apply.

Please Update Your Contact Information

Name:	_____	
Address:	_____	
City:	_____	
State:	_____	
Zip:	_____	
Home Phone:	_____	
Work Phone:	_____	
Cell Phone:	_____	☐ Opt in to text messages
Email:	_____	☐ Opt in to email

Please sign below to indicate that you agree to allow us to use this information in providing your services.

Signature

Date

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FINANCIAL POLICY

Please take a moment to read the following information regarding our financial policy.

- All patients must complete required forms prior to receiving treatment.
- We accept cash, check, any of the major credit cards (Visa, MC, American express, Discover), or Care Credit at the time dental treatment is provided.
- Minors must be accompanied by a parent or guardian unless prior arrangements have been made and the parent or guardian has accepted treatment on the minor's behalf in advance. The person who accompanies a minor/child to the appointment will be considered the responsible party and, therefore, is responsible for any payment due at the time service is rendered.

Dental Insurance

- As a courtesy for our patients with dental insurance, we will help you estimate how much you can expect your insurance to pay, and we will submit your claim to your dental insurance company. We can file most insurances, including PPO plans. **WE DO NOT ACCEPT ANY HMO PLAN.**
- Any portion not expected to be covered by your insurance is your responsibility and is **due at the time treatment is provided.** This includes deductibles and co-payments.
- Please understand that we cannot predict exactly how much your insurance company will pay and there is no guarantee of any payment by them. If after 90 days your insurance company has not paid its portion, the patient will be responsible for paying the balance in full.
- If you or your family exceed the annual limitations in any plan year, you will be responsible for the full amount of dental services. **The patient is responsible for any charges that are not covered by your insurance.**
- Please remember that we provide dental care to you, our patient, not the insurance company. If you have any questions regarding your insurance benefits, please don't hesitate to call our office to discuss your concerns.
- If you have secondary insurance, we will gladly provide the information you need to file the claim so that you can be reimbursed by your secondary insurance carrier. Being a small office, we cannot carry open balances while waiting for the second insurance payment. The patient is responsible for any amounts the secondary insurance may pay in addition to portions not covered by primary insurance.
- Pre-treatment estimates are not automatically filed, but we are happy to send one at the patient's request.
- Insurance companies say they will cover "Usual and Customary" (UCR) fees. However, most insurances have failed to keep their UCR fee schedules up to date. We are committed to keeping our fees as low as possible so that our patients can afford the treatment they need. If our fee differs from your insurance 'UCR' fee, you are responsible for the difference.

- If you have dental benefits, please bring your card and benefit information, so we may file to your insurance company. We work with most insurance, but **HMO plans are not accepted**, nor can we file a claim for an HMO policy. Please do not hesitate to call us prior to your appointment if you have any questions. Again, thank you for choosing our office. We look forward to a lifetime of continuing care.

Additional Information

- Accounts unpaid for 90 days from date of service are subject to monthly late fees (\$35 per month) and finance charges (1.5% monthly).
- If your account is 90 days past due, you may be sent to a collection agency and you will be responsible for any additional collection fees.
- Missed appointments and cancellations with less than 24 hrs notice are subject to a cancellation fee of \$25.
- Payment returned to us from your bank due to insufficient funds are subject to a \$40 NSF fee.

Signature of Patient or Parent/Guardian

Date