Kurt K. Weber D.D.S., P.A.

A BEAUTIFUL SMILE FOR YOU!

Print

Personal Information

Today's Date: _____ E-mail Address: _____

Full Name: _____ ☐ Male ☐ Female
Last First Mi Mr. Mrs. Ms. Dr.

Date of Birth: ____/____/_____ Social Security #: _____ Driver License #: _____

Home Address: _____
Street City State Zip

Home Phone #: (_____) _____ Cell #: (_____) _____ Work Phone #: (_____) _____ Ext: ___

Where & When are the best times to reach you? _____
Ex. Office phone between 10:30 – 1:00

Who can we thank for referring you? _____

Other family members seen by us? _____

Employer: _____ How long there? _____ Occupation: _____

Employer Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____ Social Security #: _____

Driver License #: _____ Employer: _____

Billing Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Date of Birth: _____ Social Security #: _____

Employer: _____ Work Phone #: (_____) _____ Ext: ___ Driver License #: _____

Insurance Information

Primary Insurance: Dental Coverage? Yes ☐ No ☐ Medical Coverage? Yes ☐ No ☐ Orthodontic coverage? Yes ☐ No ☐

Insurance Co. Name: _____ Phone #: (_____) _____ Group/Plan/Policy #: _____

Insurance Co. Address? _____
Street City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Employer Address: _____
Street City State Zip

Continue Below

Medical History

Why have you come to the dentist today? _____

Do you take any premed antibiotics before treatment? Y☐ N☐ | **If yes, which antibiotic do you take?** _____

Are you allergic to any of the following?

Aspirin	Y☐ N☐	Erythromycin	Y☐ N☐	Sedatives	Y☐ N☐
Barbiturates	Y☐ N☐	Jewelry / Metals	Y☐ N☐	Sulfa Drugs	Y☐ N☐
Codeine	Y☐ N☐	Latex	Y☐ N☐	Tetracycline	Y☐ N☐
Dental Anesthetics	Y☐ N☐	Penicillin	Y☐ N☐	Other	Y☐ N☐

Please list additional drugs/materials that cause allergic reactions: _____

Are you taking any of the following?

Acetaminophen	Y☐ N☐	Blood Thinners	Y☐ N☐	Digitalis/Heart	Y☐ N☐	Recreational Drugs	Y☐ N☐
Antibiotics	Y☐ N☐	Blood Pressure	Y☐ N☐	Medication	Y☐ N☐	Steroids/Cortisone	Y☐ N☐
Antihistamines	Y☐ N☐	Medication	Y☐ N☐	Insulin/Diabetes Drugs	Y☐ N☐	Thyroid Medicine	Y☐ N☐
Aspirin	Y☐ N☐	Cold Remedies	Y☐ N☐	Nitroglycerin	Y☐ N☐	Tranquilizers	Y☐ N☐

Do you or have you experienced the following?

Abnormal Bleeding	Y☐ N☐	Difficulty Breathing	Y☐ N☐	Herpes	Y☐ N☐	Rheumatic Fever	Y☐ N☐
Alcohol Abuse	Y☐ N☐	Drug Abuse	Y☐ N☐	High Blood Pressure	Y☐ N☐	Scarlet Fever	Y☐ N☐
Anemia	Y☐ N☐	Emphysema	Y☐ N☐	HIV+/AIDS	Y☐ N☐	Seizures	Y☐ N☐
Arthritis	Y☐ N☐	Epilepsy	Y☐ N☐	Hospitalized for Any Reason	Y☐ N☐	Shingles	Y☐ N☐
Artificial Bones/Joints	Y☐ N☐	Fainting Spells	Y☐ N☐	Kidney Problems	Y☐ N☐	Sickle Cell Disease	Y☐ N☐
Artificial Valves	Y☐ N☐	Fever Blisters	Y☐ N☐	Liver Disease	Y☐ N☐	Sinus Problems	Y☐ N☐
Asthma	Y☐ N☐	Glaucoma	Y☐ N☐	Low Blood Pressure	Y☐ N☐	Steroid Therapy	Y☐ N☐
Blood Transfusion	Y☐ N☐	Hay Fever	Y☐ N☐	Lupus	Y☐ N☐	Stroke	Y☐ N☐
Cancer	Y☐ N☐	Headaches	Y☐ N☐	Mitral Valve Prolapse	Y☐ N☐	Thyroid Problems	Y☐ N☐
Chemotherapy	Y☐ N☐	Heart Attack	Y☐ N☐	Osteoporosis/Paget's Disease	Y☐ N☐	Tonsillitis	Y☐ N☐
Chicken Pox	Y☐ N☐	Heart Murmur	Y☐ N☐	Pacemaker	Y☐ N☐	Tuberculosis	Y☐ N☐
Colitis	Y☐ N☐	Heart Surgery	Y☐ N☐	Persistent Cough	Y☐ N☐	Ulcers	Y☐ N☐
Congenital Heart Defect	Y☐ N☐	Hemophilia	Y☐ N☐	Psychiatric Treatment	Y☐ N☐	Venereal Disease	Y☐ N☐
Diabetes		Hepatitis	Y☐ N☐	Radiation Treatment	Y☐ N☐		

AUTHORIZATIONS

will be signed in office.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need. My method of payment will be _____.

_____ _____

Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandate by OSHA, the CDC and the ADA.

I certify that I am cover by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature Date

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations and Acknowledgement of Health Information Privacy Practices

Patient Name: _____

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnosis, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning your care and treatment,
- A means to communicate with health professionals who contribute to your care,
- A source for applying your diagnosis and treatment information for payment purposes.

As part of your treatment, payment, or healthcare operations, it may be necessary to disclose your health information to other healthcare providers (such as, referrals to or consultation with other healthcare professionals, laboratories, hospitals, etc.); insurance companies for payment; and/or other individuals or agencies as permitted or required by state or federal law. We also may need other healthcare entities to provide us with your healthcare information to be used for planning your care and treatment.

ACKNOWLEDGEMENT

I have been provided with a copy and the opportunity to read the "*Patient Health Information Privacy Practices",* found here at http://www.stpetebeachdentist.com/hipaa/ **that provides a more complete description of health information use and disclosure. I understand that I have the following rights:**

- The right to read the "***Patient Health Information Privacy Practices"*** prior to signing this consent,
- The right to request a copy of the ***"Patient Health Information Privacy Practices"*** for my own personal use,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Restrictions:

I request that the following restrictions to the use or disclosure of my health information:

_____

(Per HIPPA rules, the practice retains the right for final decision as to honor the request for restrictions)

I fully understand and agree to this consent, and acknowledge the above rights and disclosures.
(Signed In-Office)

_____ _____ _____

Signature | Print name of person signing | Date

FOR OFFICE USE ONLY

[ ] "Consent form" reviewed by (Employee) _____ on (Date) _____

[ ] Patient refused to sign the consent form.

[ ] Reason for patient refusal to sign _____

[ ] Restrictions were added by the patient (see restrictions above)

Patient is responsible for ANY and ALL costs incurred in the Collection of An Unpaid Balance including but not Limited to Attorney and Court Costs.

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Kurt K. Weber, D.D.S., P.A. docdockw@gmail.com
5901 Sun Blvd., Suite 115, St. Petersburg, Fl. 33715 727.867.3400 Fax: 727.864.9094
1012 MLK, West, Seffner, Fl. 33584 813.689.9100 Fax: 813.6534990

NOTICE TO OUR PATIENTS

Effective December 1, 2014.

Failure to keep appointments or cancellations of appointments with less than 24 hours' notice will incur a non-refundable, administrative fee of $50.00 dollars.

Antibiotic premedication prescriptions can either be called in or a prescription provided for our patients ***prior*** to appointment.

The fee for in-office medications is $16.00 dollars. This fee covers the cost of providing this service to our patients.

Improved appointment compliance should allow us to better plan for patient care and make everyone's day go more smoothly.

While pain and dental suffering tend not to keep a schedule, we will do our best to keep respectful awareness of our patient's own time schedules.

Please call prior to your appointment to verify timing and see if out patient needs have kept kept on track or are running behind.

I am confident that if we all partner together our patient's dental experience can be the best possible!

Understandably, things do come up in everyday life. For this reason, I think we can make single exceptions on a case by case basis as needs dictate.

Thank you again for the opportunity to care for your dental needs,

Kurt Weber DDS

Signed in-office

I have read and understand the above,

_____ _____
Signature Date

_____
Print Name

Print

Please print this form or save and email it to docdockw@gmail.com

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