



**PHARMACY INFORMATION**

House Bill 831 (2019), Electronic Prescribing, was signed into law by Governor DeSantis. The effective date is January 1, 2020.

*The bill provides important new requirements for prescribers to generate and transmit all prescriptions electronically.*

**Patient Name:** \_\_\_\_\_

**Name of Pharmacy:** \_\_\_\_\_

**Address / Crossroads:** \_\_\_\_\_

**City:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**All information entered above is for office use only.**



## HIPPA COMPLIANCE

**Patient's Name:** *(Please Print)* \_\_\_\_\_

LAST NAME

FIRST NAME

MIDDLE

1. Do we have permission to send recall/treatment appointment reminders to your home?  Yes  No
2. Do we have your permission to leave the following information on your home answering machine or voicemail?

Appointment Confirmation  Yes  No  
Billing Information  Yes  No  
Dental/Medical information  Yes  No

3. Do we have your permission to leave the following information on your work answering machine or voicemail?

Appointment Confirmation  Yes  No  
Billing Information  Yes  No  
Dental/Medical information  Yes  No

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Confirmation  Yes  No  
Billing Information  Yes  No  
Dental/Medical information  Yes  No

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

Appointment Confirmation  Yes  No  
Billing Information  Yes  No  
Dental/Medical information  Yes  No

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Confirmation  Yes  No  
Billing Information  Yes  No  
Dental/Medical information  Yes  No

7. I hereby give permission to share any information concerning me with the person(s) named below:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SIGNED:** \_\_\_\_\_

Print Name: \_\_\_\_\_

**WITNESS:** \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Child  Legal Guardian  Other:



**Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio)  
TERMS AND CONDITIONS OF SERVICE**

In consideration of all services provided by **Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio)** and its employees, contractors and/or affiliates, the undersigned hereby acknowledges and agrees (on behalf of himself or herself and his or her children, dependents and other persons for whom he or she serves as guarantor (collectively, "Dependents") with the following terms and conditions of service:

**Medical Information.** The undersigned hereby certifies that all information provided to Elan Salee D.M.D., P.A. is true, correct and complete and agrees promptly inform Elan Salee D.M.D., P.A. of any changes in any information (including regarding any Dependent). Elan Salee D.M.D., P.A. is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information/medical records relating to the undersigned or any Dependent to obtain payment for services, determine insurance benefits or otherwise as required by law. Elan Salee D.M.D., P.A. is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any Dependent).

**Treatment; Informed Consent.** The undersigned authorizes Elan Salee D.M.D., P.A. and any treating dentist, hygienist and/or staff to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself/herself or any dependent. Dentistry is a biological procedure and not an exact science; therefore, despite the highest standard of care, no guarantee is or can be given by Elan Salee D.M.D., P.A. or any dentist or any other person employed or contracted by Elan Salee D.M.D., P.A. regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures and continuing care and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or retreatment) with additional fees. Failure to show in 15 minutes of the scheduled time for, or provide at least 48 hours advance notice of cancellation of, any appointment for any reason will result in a broken appointment fee. Elan Salee D.M.D., P.A. does not exercise control over the professional services of any of its treating dentists; therefore, the undersigned shall solely hold the treating dentist responsible for any treatment performed (including, without limitation, treatment provided under the treating dentist's supervision) and agrees to hold Elan Salee D.M.D., P.A. and its officers, directors, owners and affiliates harmless from any claim, suit, loss or damage related to any dental treatment. Fees in treatment plans for non-insurance/discount plan patients are only valid for 30 days; all insurance/discount plan fees are subject to change at any time based upon changes in plan fee schedules or to correct errors.

**Financial Responsibility; Insurance.** **THE UNDERSIGNED PATIENT AND/OR GUARANTOR ASSUME FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES AND CHARGES FOR ALL SERVICES OF ELAN SALEE D.M.D., P.A. (DBA: BOYNTON DENTAL STUDIO), WHETHER OR NOT COVERED BY INSURANCE, THE PATIENT'S PORTION OF ALL FEES (INCLUDING ALL DEDUCTIBLES AND CO-PAYS) IS DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE PERFORMED** (for treatment involving multiple appointments, such as a crown, root canal, denture or implant, the entire patient portion is normally due when treatment is started). Any special financial arrangements must be made before treatment is started, all insurance, discount plans and discount coupons must be presented before treatment is started. Elan Salee D.M.D., P.A. submits insurance claims solely to primary dental insurance for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. **Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed.**

The undersigned agrees to promptly pay on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 1 ½% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balances are considered past due if not paid within the 60 days after the date of service. The undersigned shall pay all costs incurred by Elan Salee D.M.D., P.A. relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. Elan Salee D.M.D., P.A. reserves the right to terminate or deny any treatment if the patient's account is delinquent.

**Assignment of Benefits; Authorization and Release.** The undersigned hereby certifies that all insurance coverage described above is current and valid and assigns directly to Elan Salee D.M.D., P.A. all insurance benefits covering the undersigned or any Dependent for all services rendered. The undersigned hereby agrees that his/her signature below will be maintained "on file"; Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio) is authorized to use such signature on all applicable insurance claims and submissions. If any insurance payment is made to the undersigned, he/she will immediately remit such payment to Elan Salee D.M.D., P.A.

**Notice of Privacy Practices.** The undersigned has reviewed a copy of Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio) notice of Privacy Practices effective April 14, 2003, as amended.

**I have read the above terms and conditions of service by Elan Salee D.M.D., P.A. (DBA Boynton Dental Studio and understand and accept such terms:**

\_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_  
Signature of Patient

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of Responsible Party/ Guarantor (For minors, parent or legal guardian must sign)

## PATIENT'S HEALTH INFORMATION

Date of last Dental Visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

### Have you ever had any of the following health problems, conditions or habits?

|   |   |   |   |
|---|---|---|---|
| <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> AIDS<br><input type="checkbox"/> <input type="checkbox"/> Allergy (Codeine)<br><input type="checkbox"/> <input type="checkbox"/> Allergy (Penicillin)<br><input type="checkbox"/> <input type="checkbox"/> Allergy (Other) _____<br><input type="checkbox"/> <input type="checkbox"/> Anemia  | <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> Jaundice<br><input type="checkbox"/> <input type="checkbox"/> Diabetes<br><input type="checkbox"/> <input type="checkbox"/> Dizziness<br><input type="checkbox"/> <input type="checkbox"/> Epilepsy<br><input type="checkbox"/> <input type="checkbox"/> Excessive<br><div style="text-align: center;">Bleeding</div> <input type="checkbox"/> <input type="checkbox"/> Fainting<br><input type="checkbox"/> <input type="checkbox"/> Glaucoma  | <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> <input type="checkbox"/> Liver Disease<br><input type="checkbox"/> <input type="checkbox"/> Mental Disorders<br><input type="checkbox"/> <input type="checkbox"/> Mitral Valve<br><input type="checkbox"/> <input type="checkbox"/> Nervous Disorders<br><br><input type="checkbox"/> <input type="checkbox"/> Pacemaker<br><input type="checkbox"/> <input type="checkbox"/> Pregnancy<br><div style="text-align: center;">Due Date: _____</div> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> <input type="checkbox"/> Radiation Treatment<br><input type="checkbox"/> <input type="checkbox"/> Respiratory Problems<br><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> <input type="checkbox"/> Rheumatism<br><input type="checkbox"/> <input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease (Including HIV / Aids)<br><input type="checkbox"/> <input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> <input type="checkbox"/> Cough up blood<br><input type="checkbox"/> <input type="checkbox"/> Cough, Persistent<br><input type="checkbox"/> <input type="checkbox"/> Smoking _____ / day _____ / year | <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> Stomach Problems<br><input type="checkbox"/> <input type="checkbox"/> Stroke<br><input type="checkbox"/> <input type="checkbox"/> Swelling feet / ankles<br><input type="checkbox"/> <input type="checkbox"/> Substance Abuse<br><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems<br><br><input type="checkbox"/> <input type="checkbox"/> Tobacco Habit<br><input type="checkbox"/> <input type="checkbox"/> Tonsillitis<br><br><input type="checkbox"/> <input type="checkbox"/> Tumors<br><input type="checkbox"/> <input type="checkbox"/> Ulcers<br><input type="checkbox"/> <input type="checkbox"/> Venereal Disease<br><input type="checkbox"/> <input type="checkbox"/> Other: |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism<br><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves<br><br><input type="checkbox"/> <input type="checkbox"/> Artificial Joints, Pins<br><input type="checkbox"/> <input type="checkbox"/> Asthma<br><input type="checkbox"/> <input type="checkbox"/> Back Problems<br><input type="checkbox"/> <input type="checkbox"/> Bleeding Abnormally<br><input type="checkbox"/> <input type="checkbox"/> Blood Disease<br><input type="checkbox"/> <input type="checkbox"/> Cancer<br><input type="checkbox"/> <input type="checkbox"/> Chemical Dependency<br><input type="checkbox"/> <input type="checkbox"/> Circulatory Problems<br><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect<br><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> <input type="checkbox"/> Growths<br><input type="checkbox"/> <input type="checkbox"/> Hay Fever<br><input type="checkbox"/> <input type="checkbox"/> Headaches<br><input type="checkbox"/> <input type="checkbox"/> Head Injuries<br><input type="checkbox"/> <input type="checkbox"/> Heart Disease<br><input type="checkbox"/> <input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> <input type="checkbox"/> Hemophilia<br><input type="checkbox"/> <input type="checkbox"/> Hernia Repair<br><input type="checkbox"/> <input type="checkbox"/> Sinus Problems<br><input type="checkbox"/> <input type="checkbox"/> Skin Rash<br><input type="checkbox"/> <input type="checkbox"/> Jaw Pain |   |   |

### Have you ever had any if the following dental problems or conditions? Please check those that apply:

|   |   |  |   |
|---|---|--|---|
| <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> Bad Breath<br><br><input type="checkbox"/> <input type="checkbox"/> Bad Taste<br><input type="checkbox"/> <input type="checkbox"/> Bleeding Gums<br><input type="checkbox"/> <input type="checkbox"/> Clicking / Popping of Jaw<br><br><input type="checkbox"/> <input type="checkbox"/> Food caught in teeth | <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> Grinding or<br><div style="text-align: center;">Clenching Teeth</div> <input type="checkbox"/> <input type="checkbox"/> Loose Teeth<br><input type="checkbox"/> <input type="checkbox"/> Broken Fillings<br><input type="checkbox"/> <input type="checkbox"/> Periodontal<br><div style="text-align: center;">Treatment</div> <input type="checkbox"/> <input type="checkbox"/> Sensitivity to Cold | <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> Sensitivity to sweets<br><input type="checkbox"/> <input type="checkbox"/> Sensitivity to Hot<br><input type="checkbox"/> <input type="checkbox"/> Sensitivity when Biting<br><input type="checkbox"/> <input type="checkbox"/> Sores /<br><div style="text-align: center;">Growth in the Mouth</div> <input type="checkbox"/> <input type="checkbox"/> Braces | <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> Nitrous Oxide<br><br><input type="checkbox"/> <input type="checkbox"/> Prolonged Bleeding<br><input type="checkbox"/> <input type="checkbox"/> General Anesthetic<br><input type="checkbox"/> <input type="checkbox"/> Extractions<br><br><input type="checkbox"/> <input type="checkbox"/> Local Anesthetic -<br><div style="text-align: center;">Novocain</div> |
|---|---|--|---|





**PATIENT REGISTRATION**

**PATIENT INFORMATION**

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Last First Preferred Name

**Address:** \_\_\_\_\_  
Street Apartment #  
\_\_\_\_\_  
City State Zip Code

**Email:** \_\_\_\_\_ **Gender:**  Male  Female **Family Status:**  Single  Married  Child

**Social Security #:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Driver's License #:** \_\_\_\_\_ **\*\* Office Use Only \*\***

**\*\* HIPPA \*\*** Do we have your permission to leave appointment, billing or dental information on your answering machine, voicemail or e-mail at the following numbers? Please check "Yes" or "No" for each contact number.

**Home Phone:** \_\_\_\_\_  Yes  No **Best time to call:** \_\_\_\_\_  
**Work:** \_\_\_\_\_  Yes  No **Best time to call:** \_\_\_\_\_  
**Cell Phone:** \_\_\_\_\_  Yes  No **Best time to call:** \_\_\_\_\_  
**Cell Text Message:** \_\_\_\_\_  Yes  No  
**E-mail:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**In case of an emergency, contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**RESPONSIBLE PARTY / GUARANTOR INFORMATION**

Only if the person responsible is NOT the patient, complete the following information for the Guarantor.

**Guarantor Name:** \_\_\_\_\_

**Relationship to Patient:**  Self  Spouse  Child  Other

**Gender:**  Male  Female **Family Status:**  Single  Married  Child  Divorced

**Address:** \_\_\_\_\_  
Street City State Zip Code

**Social Security #:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Driver's License #:** \_\_\_\_\_ **\*\* Office Use Only \*\***

**Phone Numbers:** Home: \_\_\_\_\_ Cell: \_\_\_\_\_ **Email:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_  
Street City State Zip Code

**REFERRAL INFORMATION**

How did you learn about, or who referred you to our dental office?  Patient / Friend  Our Staff  Another Dental Office  
 Insurance Plan  Website  Newsletter  School  Your Employer  Other

Name of person, dental or medical office that referred you: \_\_\_\_\_