Everest Dental

Please Print Patient Information

Name _____ Date of Birth ____/____/____

Address _____ Email _____

City_____ State_____ Zip_____ Refer by _____

Home phone_____ Cell phone_____ Work phone _____

Emergency contact _____ Phone _____ Relation _____

Social Security_____ Employer _____

Do you have Dental Insurance? _____ If (yes) Carrier _____ ID#_____

Member name _____ Date of Birth ____/____/____

Notice to our Insurance Patients

Your Insurance Company will only pay for those services they deem to be necessary and falls under the covered services of you policy. If for any reason your Insurance Company determines our diagnosis and treatment does not meet the criteria of your contract, they may deny payment to the practice. In this case charges for those services will become the patient's responsibility. We will work with you to appeal any such findings by your Insurance Company resulting in a denial. If payment is still denied by your policy, the responsibility for payment is transferred to the patient.

By signing below you acknowledge that your Insurance Company may deny benefits to this practice for services provided. In such a case, you agree to be personally responsible for payments. Your Dental Insurance is a contract between you and your Insurance Company.

Patient Signature _____ Date: _____

Dr. Gayed
Everest Dental Oviedo
2989 Alafaya Trail
Oviedo, Florida 32765
contacteverestdental@gmail.com
407-695-7774

Everest Dental

Medical and Dental History

Patient name _____ Date of Birth ____/____/____

Are you allergic to medications / Anticoagulant? (yes) or (no) if yes please list _____

_____

Are you presently taking any medications? (yes) or (no) if yes please list _____

_____

Are you under a Physician care? (yes) or (no) if yes reason? _____

Physician's name _____ Phone _____

Do you have or have you ever had the following?

Heart Murmur	Yes / No	Artificial Joints	Yes / No
Venereal Disease	Yes / No	Tuberculosis	Yes / No
Rheumatic Fever	Yes / No	Heart problems	Yes / No
AID/HIV	Yes / No	Pace Maker	Yes / No
History of Bleeding	Yes / No	Kidney Disease	Yes / No
Diabetes	Yes / No	Hepatitis, Jaundice or Liver Problems	Yes / No
High Blood Pressure	Yes / No		
Anemia	Yes / No		
Thyroid Problems	Yes / No	**Woman**	
Epilepsy / Seizures	Yes / No	Are you Pregnant?	Yes / No
Herpes / Cold Sores	Yes / No	Taking Contraceptives	Yes / No
Do you smoke?	Yes / No		
Reaction to Anesthetic	Yes / No		

What is the main reason for your visit today (pain, emergency, exam)? _____

When was your last cleaning (estimate)? _____

Do your gums bleed? Yes / No

Are you happy with your smile? Yes / No

Do you feel your teeth need Braces or Invisalign? Yes / No

Do you feel you need cosmetic treatment or whitening? Yes / No

Dr. _____

EVEREST DENTAL

2989 Alafaya Trail Oviedo FL 32765
(407)-695-7774

Acknowledge Of Privacy Practices

My signature confirms that I have been informed of rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can be and will be used to.

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date:_____

Signature: _____

Relationship to whom we may disclose your health information to:

_____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:
___The patient refused to sign
___Communication barriers
___Emergency situations
___Other

Everest Dental Oviedo

READ BEFORE SINGING

Alternative Benefits Clause

Many dental insurances agreements contain an “Alternative Benefits Clause”. This clause maintains that if there is an equally beneficial, but less expensive material that can be used to repair or replace a tooth, the insurance company will pay at least expensive rate. This includes, but not limited to molar crowns, composite “white” fillings and fixed bridges.

Because we are only providers, not beneficiaries on your insurance policy, we are not aware of the provision of your particular alternate benefits clause until the claim has been file and reviewed by your dental insurance company. If a procedure is performed and an alternative benefits is applied by the insurance company, the patient is responsible for any non-coverage charges.

Estimate of Benefits

The treatment plan given by the staff is an **ESTIMATE OF BENEFITS ONLY**. Once the claim is reviewed by your insurance company, your insurance company will determine what benefits are payable and at what rate. We are **NOT RESPONSIBLE** for any fees that not cover by your insurance company.

If you have any questions about your insurance policy, we will try our hardest to assist you. If there is something that we cannot assist you with **PLEASE FEEL FREE TO CALL YOUR INSURANCE COMPANY WITH ANY QUESTIONS.**

I UNDERSTAND AND AGREE TO THE ABOVE WRITTEN POLICY

Patient Signature _____ Date: _____

Everest Dental Oviedo

MISSED APPOINTMENT CONSENT

Missed Appointment/Late Cancel Policy

We feel the doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your schedule appointments, and ask that you give us the same courtesy. We understand that unforeseen circumstances occasionally occur and you will be unable to keep your scheduled appointment. Please see our missed/cancelled appointment guidelines below.

If you are unable to keep your schedule appointment, we require a 48-hour notice (2- full business day) so that we may accommodate the dental needs of another patient. This guideline applies to both visits with our hygienist and our doctor. If an appointment is cancelled or rescheduled within 48 hours of the reserved appointment time, Everest Dental may charge the patient a small cancellation fee.

Hygiene Visits: All patients will receive the opportunity to miss one scheduled appointment. A $30 fee will be charge to the patient account for any additional cancel/failed appointments.

Doctor Visits: Because we do not schedule several operative patients at the same time, all appointments are reserved exclusively for you. In the event of a cancel/failed doctor's appointment, the patient is charged a $30 fee.

Thank you for choosing Everest Dental as your dental health provider.

Dr. Peter Gayed

Patient Signature: _____

Date:_____