PERIODONTICS & IMPLANT DENTISTRY
of Tallahassee

Matthew Rasmussen, DMD
Periodontist
P: 850.692-9200
F: 850.800.9341
4012 Kelcey Court
Suite 102
Tallahassee, FL 32308

Personal Information

Name:_____Employed/Retired/Student/Non-Employed

Relationship to Patient: Self/Spouse/Child

Social Security No._____ Email Address: _____

Sex: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Person/Phone Number: _____

Preferred Pharmacy Name: _____Phone Number: _____

Address: _____ City: _____ State: _____Zip Code: _____

Insured Information

Insured Name: _____ Relationship to Insured: _____

Date of Birth: _____

Employer: _____ Work Phone: _____

Employer Address: _____

City: _____ State: _____Zip Code: _____

Social Security No. Of Insured OR Member ID: _____

Insurance Company & Address: _____

City: _____State: _____Zip Code: _____

Group No.: _____

General History

Chief Concern: _____

Referred By: _____ General Dentist: _____

Frequency of Dental Visits: _____ Do you wear a removable appliance? _____

Difficulties with Past Treatment: _____

Medical History

Have you been diagnosed with Osteopenia or Osteoporosis? _____

If so, what medications are you presently taking for it? _____

Are you now, or have you been, under the care of a physician during the past 12 months? _____

Last visit with Physician: _____ Purpose: _____

Name of Physician: _____ Phone No.: _____

Please list any known allergies or sensitivities to medications: _____

List any medications you are presently taking (*including any over the counter supplements and vitamins)*:

_____

Smoking Intake: _____ Alcohol Intake: _____ Other_____

Are you in good health?	Yes	No	Kidney trouble	Yes	No
Tuberculosis	Yes	No	Arthritis or painful swollen joints	Yes	No
Persistent cough or cough			Persistent swollen glands in neck	Yes	No
that produces blood?	Yes	No	Stomach ulcer or hyperacidity	Yes	No
Have there been any changes			Low blood pressure	Yes	No
in your general health in the			High blood pressure	Yes	No
past year?	Yes	No	Sexually transmitted disease	Yes	No
Have you ever been hospitalized			Epilepsy or other neurological disease	Yes	No
for a serious illness?	Yes	No	Problems with mental health	Yes	No
Do you or have you had any of the			Cancer/Tumor/Growth	Yes	No
following diseases or conditions?			Diabetes	Yes	No
Cardiovascular disease	Yes	No	Are you undergoing chemotherapy?	Yes	No
Heart Murmur	Yes	No	Have you ever had an		
Mitral Valve Prolapse	Yes	No	organ transplant?	Yes	No
Rheumatic Fever	Yes	No	Are you taking daily aspirin?	Yes	No
Artificial pin(s)	Yes	No	Are you taking any sleeping aids?		
Artificial joint(s)	Yes	No	(Ambien, melatonin, etc.)	Yes	No
Allergies	Yes	No	Do you have any disease, condition		
Abnormal bleeding	Yes	No	or problem that is not listed above?	Yes	No
Blood disorder such as Anemia	Yes	No	If so, explain: _____		
Blood transfusion	Yes	No			
Sinus trouble	Yes	No	*Females Only:* Are you pregnant?	Yes	No
Asthma or hay fever	Yes	No			
Fainting spells or seizures	Yes	No			
Persistent diarrhea	Yes	No			
Recent weight loss	Yes	No			
Hepatitis	Yes	No			
Jaundice or liver disease	Yes	No			
AIDS or HIV infection	Yes	No			
Thyroid problems	Yes	No			
Respiratory problems, emphysema,					
bronchitis, etc.	Yes	No			

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I hereby authorize photos, slides, X-rays, or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry. I also acknowledge receipt of Periodontics and Implant Dentistry of Tallahassee's Notice of Privacy Practices.

Signature of Patient: _____

Date: _____

PERIODONTICS & IMPLANT DENTISTRY
of Tallahassee

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

Please understand that payment of your bill is considered part of your treatment.

The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

Please Note: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for all professional services rendered. This includes but is not limited to dental fees, surgical procedures, tests, office procedures, medications and any other services not directly provided by the dentist.

INSURANCE:

As a courtesy to you, we will help you process all your dental insurance claims, though we do not file to a secondary insurance.. Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request.

It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits you or your employer has purchased for you.

Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums which are your responsibility.

Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefit ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to several reasons, specifically related to your plan.

Insurance payments are ordinarily received within 30-90 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether your insurance company pays any portion.

PERIODONTICS & IMPLANT DENTISTRY
of Tallahassee

PAYMENT:

To minimize the need for Cancellation or No-Show fees, our office requires the estimated patient portion to be paid **at the time of scheduling.**

Our office accepts cash, personal checks (this is excluding the New Patient Exam fee), MasterCard, Visa, Discover, American Express, CareCredit, Alphaeon, Cherry, Proceed, and Lending Club.

REFUNDS:

Any refunds will be processed to the original method of payment. If a refund by check is necessary due to the original payment method being unavailable, a 3% processing fee will be applied.

CANCELLATIONS/NO-SHOWS:

After **two (2)** cancellations or no-shows with less than 24-hour notice, appointments will be seen on a walk-in basis only, subject to availability.

LATE/TARDINESS POLICY

Please be aware that if you arrive more than 10 minutes late, we may need to reschedule your visit. To respect the time of all our patients and ensure efficient care, we kindly ask that you arrive promptly for your appointment. This policy help us minimize wait times and provide the best care possible to everyone.

I have read the Periodontics and Implant Dentistry of Tallahassee Financial Agreement. I understand and agree to the terms and conditions of this Financial Agreement.

Signature: _____

Date: _____

PERIODONTICS & IMPLANT DENTISTRY
of Tallahassee

HIPAA Compliance Authorizations

_____ A copy of our HIPAA Compliance and our Privacy Practices has been made available to me. By initialing, I agree and accept the terms of this authorization and disclosure.

[ ] Please check here if you **do not** want us to leave messages on your answering machine or with a household family member

[ ] Please check here if you **do not** want us to leave a message on your mobile voicemail.

[ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

- **If you choose**, please list by name and relationship the persons with whom we may share your healthcare or payment information:
  _____
  _____

* If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient:
YES [ ] No [ ] RELATIONSHIP: _____

Authorization for Photography and Testimonials

_____ A copy of our Authorization for the Use of Photography and Testimonials has been made available to me. By initialing, I agree and accept the terms of this authorization.

I hereby certify that all the information provided is true and correct, and I have been given the opportunity to ask any questions regarding the policies and procedures set forth by Periodontics and Implant Dentistry of Tallahassee.

_____	_____	_____
Print Patient Name	Signature	Date
_____	_____	_____
Print Witness Name	Signature	Date