WELCOME TO OUR OFFICE

Dr. Robert Spoont & Associates
General Dentistry

PATIENT INFORMATION

Patient Name:________________________________ Today's Date________________
Last First MI

☐ Male ☐ Female ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

Social Security #________________________ Date of Birth ________________

Phone: Home ( )____________ Work ( )____________ Cell ( ) ____________

Address____
Street Apartment #

____
City State Zip Code

E-Mail Address (Needed to Confirm Appointments)________________________

Marital Status: [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Single

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HEALTH INFORMATION

Date of Last Dental Visit:__________ Date of last x-rays__________ Name of Previous Dentist __________

Have you ever had any complications following dental treatment? ☐ yes ☐ no

If yes, please explain____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ yes ☐ no

If yes, please explain____

Are you now under the care of a physician? ☐ yes ☐ no If yes, please explain ____________________

Are you now taking any medication? ☐ yes ☐ no If yes, please list________________________

Name of Physician:____________________ Phone ____________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS or HIV Positive	☐ Blood/Bleeding disorder	☐ Heart Disease/Surgery	☐ Pregnant Now?
☐ Allergies: Penicillin	☐ Cancer	☐ Heart Murmur/Rheum. Fever	☐ Radiation/Chemotherapy
☐ Allergies: Codeine	☐ Diabetes	☐ Stomach Problems/Ulcer	☐ Stroke
☐ Allergies:________	☐ Dizziness/Fainting	☐ Hepatitis (Liver Disease)	☐ Tuberculosis
☐ Anemia	☐ Ear Disease	☐ High Blood Pressure	☐ Tumors/Growth
☐ Arthritis/Joint Disease	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Venereal Disease
☐ Artificial Joints	☐ Eye Disease	☐ Mental/Nervous Disorder	☐ Other________
☐ Astma/Resp. Disease	☐ Glandular/Hormonal Dis.	☐ Pacemaker	☐ Other________

Do you have any health problems that need further clarification? ☐ yes ☐ no

If yes, please explain____

Emergency contact other than your spouse: Name______________Phone:__________Relation: ________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?________________________

Please list any other immediate family members who are patients of this office ________________

____

OVER →

FINANCIAL INFORMATION

Who will pay account? ______________________ Relationship to patient ______________________

YOUR EMPLOYMENT: ______________________ **SPOUSE'S NAME:** ______________________

Occupation ______________________ Spouse's occupation ______________________

Employer ______________________ Employer ______________________

Work Address ______________________ Work Address ______________________

City ____________ State ______ Zip ______ City ____________ State ______ Zip ______

Your Social Security # ______________________ Your Social Security # ______________________

DENTAL INSURANCE INFORMATION

Primary: Name of insured: ______________________ Is insured a patient? ☐ yes ☐ no

Insured's birth date: ____________ ID # ____________ Group # ____________

Insured's address: ______________________
Street City State Zip

Insured's Employers Name ______________________

Address: ______________________
Street City State Zip

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other ______________________

Insurance plan name: ______________________

Address: ______________________
Street City State Zip

Secondary: Name of insured: ______________________ Is insured a patient? ☐ yes ☐ no

Insured's birth date: ____________ ID # ____________ Group # ____________

Insured's address: ______________________
Street City State Zip

Insured's Employers Name ______________________

Address: ______________________
Street City State Zip

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Other ______________________

Insurance plan name: ______________________

Address: ______________________
Street City State Zip

AGREEMENT FOR DENTAL SERVICES

1. **The patient (or if a minor, parent(s) or legal guardian) hereby retains either Dentist or their associates to render dental services to and for the benefit of the patient.**
2. **The patient (parent or legal guardian) hereby agrees to pay for all the bills and charges for services promptly. The charges are due at the time services are rendered.**
3. **The patient (parent or legal guardian) acknowledges that he/she is responsible for all charges incurred in the rendering of dental services, regardless of what type of insurance he/she carries. Any action by this office to process applications for insurance or other benefits on behalf of the patient will not relieve the patient of the obligation to pay the bill. The patient further understands that any failure by the insurance company or other provider of benefits to pay for all or part of the patient's bill will not excuse the obligation to pay all the amount for service rendered. Our office will make every effort to assist you in filling and processing claims.**
4. **In the event that this office finds it necessary to resort to collection action due to an unpaid bill, the patient (parent or legal guardian) agrees to pay all cost, expenses, and attorney's fees associated with collection.**
5. **I authorize Freedman & Spoont to bill my insurance carrier for services rendered.**

______________________ ____________ ______________________

Signature of patient, parent or guardian Date Relationship to patient

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH IMFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

*CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **BIG TOOTH BOCA / BIG BOCA SMILES.,** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de **BIG TOOTH BOCA / BIG BOCA SMILES., y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

Patient Name: *(please print)* ____________________
Nombre Del Paciente: *(nombre en letra de molde por favor*

Patient Signature *(or legal representative; proof may be requested)* ____________________
Firma Del Paciente: *(o representante legal; prueba puede ser requerida)*

Date: *(dd/mm/yy)* ____________________
Fecha: *(dd/mm/aa)*

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM *CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **BIG TOOTH BOCA / BIG BOCA SMILES., (BTB/BBS)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **BTB/BBS** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **BTB/BBS** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **BTB/BBS** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **BIG TOOTH BOCA / BIG BOCA SMILE., (BTB/BBS)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **BTB/BBS** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **BTB/BBS** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **BTB/BBS** y yo y consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

My Consented Email Address is: ____________________
***Mi Correo Electrónico Consentido es:**

My Consented for Text Messaging to: ____________________
***Mi Mensaje de Textos consentido a:**

X ____________________
Patient Signature *** Firma del Paciente**

____
Date ***Fecha**

SEE BACK SIDE

FOR BOTH PEDIATRIC AND ADULT PATIENTS :
If we may discuss the treatment with anyone else, even if a relative, please list:

______________________ ______________________ ______________________

Signed______________________

Print Name______________________

Date______________________

INFORMATIONAL PURPOSES ONLY

COSMETIC TREATMENT

(INCLUDING BLEACHING, WHITENING, BONDING AND VENEER)

I UNDERSTAND that treatment of my dentition for which I desire cosmetic dental procedures to be performed may entail certain risks and possible unsuccessful results, with even the possibility of failure to achieve the results which may be desired or expected. I agree to assume those risks, possible unsuccessful results and/or failure associated with, but not limited to the following: (Even though care and diligence is exercised in this subject treatment, there are no guarantees of anticipated or desired results nor of the longevity of the treatment).

1. **Reduction or roughening of tooth structure:** In making preparation of teeth for the reception of cosmetic veneers, it may be necessary to slightly reduce or roughen the surface of the tooth to which the veneer(s) may be bonded. This preparation will be done as conservatively as possible. If the veneer covering breaks or comes off, the uncovered tooth may become more decay susceptible.

2. **Sensitivity of teeth:** Even though, in the majority of the cases (whitening, bleaching, bonding, and veneering teeth) there is usually no appreciable sensitivity, this type of treatment may cause teeth to become sensitive. Should sensitivity occur and persist for any length of time, please contact this office for an examination.

3. **Chipping, breaking or loosening of the veneer.** No matter how well done, this could occur. Many factors may contribute to this happening such as: mastication of excessively hard materials; changes in occlusal (biting) forces; traumatic blows to the mouth; breakdown of the bonding agents; and other such conditions over which the doctor has no control.

4. **Sensitive or allergic reactions of soft tissues to whitening, bleaching, or bonding agents:** Even though this is an unusual occurrence, the gums or soft tissues of the mouth which may be exposed to the various agents used in these procedures may exhibit an allergic response. Also, gum tissues may in some cases exhibit signs of inflammation. Should this occur, please contact this office to be examined.

5. **Esthetics/Appearance:** Every effort possible will be made to match and coordinate both the form and shade of veneers and/or bonding agents which will be placed in order to be cosmetically pleasing to the patient. However, there are some differences which may exist between the natural dentition and the materials which are artificial, making it impossible to have the shade and/or form perfectly match your natural dentition.

6. **Longevity:** It is in possible to place any specific time criteria on the length of time that veneers and bonding should last or for the lightened appearance of whitened or bleached teeth to maintain the lightened shades. These time periods may vary from a very short time to a very long time depending upon many conditions existing from patient to patient, and/or upon each patient's individual habits or circumstances, which may be either internal, external or both.

7. It is the patient's responsibility to immediately inform the doctor and seek attention from him/her should any undue or unexpected problems occur or if the patient is dissatisfied. Also, all instructions must be diligently followed, including scheduling and attending all appointments.

INFORMED CONSENT TO TREATMENT: I have been given the opportunity to ask any and all questions regarding the nature and purpose of cosmetic dental treatment and have received all answers to my satisfaction. I voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for these services have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. ________________________ and/or his/her associates to render any treatment deemed necessary, desirable, and/or advisable to me, including the administration and/or prescribing of any anesthetics and/or medications.

______________________	______________________	__________
Patient's Name (please print)	Signature of patient, legal guardian, or authorized representative	Date

Tooth No.(s) ______________________

____

____

______________________	__________
Witness to signature	Date

(Rev. 1/1/96)

WAIVER AND CONSENT

I, ______________________________________ the undersigned, do hereby authorize and consent to the use of certain photographs/x-rays of me taken by ________________________ ______________________. I hereby grant them permission to reproduce, publish, print, use and distribute copies of such photographs/x-rays either in an official medical publication or in the form of prints, slides or film for use in connection with articles and lectures dealing with jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such pictures without my express consent in each instance.

NO FULL-FACE OR IDENTIFYING PHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITTEN CONSENT FOR EACH ONE.

Polaroid photography taken during treatment are used by our laboratories for cosmetic purposes for the fabrication of your crowns, bridges or dentures and are a part of your permanent dental record.

____
Patient's Signature and/or Guardian

____
Patient's Address

____
Date

Please initial one of the following:

_____ I do not consent to the use of slides or photography for use in dental education or publications.

_____ I do consent to the use of slides or photographs for use in dental education or publications.

_____ I do consent to the use of slides or photography EXCEPT full face or identifying views.

Michael Cohen, D.M.D.
21301 Powerline Rd.
Suite 208
Boca Raton, Fl 33433

AGREEMENT FOR DENTAL SERVICES

I, ______________________, patient, hereby retains Michael Cohen to render dental services to and for the benefit of the patient.

The patient hereby agrees to pay for all the bills and charges for the services rendered.

The patient acknowledges that he/she is responsible for all the charges incurred regardless of what insurance he/she carries. The office will file the insurance claims for the patient but regardless what the insurance company pays, the patient is responsible for the balance. If for any reason the insurance company denies the claim, the patient is responsible for the entire balance due for the treatment.

In some instances the procedures are covered by his/her insurance but the yearly allowed maximum is used for prior work in another office such as root canal, extractions or periodontal work , therefore there would not be any more funds allowed and payment in full would be due by the patient.

I, ______________________ authorize Dr Michael Cohen to bill the insurance carrier for the services rendered.

Signature ______________________ Date____________