**Joshua M. Ferraro D.D.S.**
1708 South Alexander
Street Plant City, FL 33563
813-752-5600

# *Welcome to Our Practice!*

On behalf of my team, I want to welcome you to our office. We are pleased that you have selected us to care for your dental needs, and we look forward to your initial visit.

We want you to know that we are committed to provide you with the highest quality of oral health care, in the most gentle and efficient manner possible. We pride ourselves on making dentistry a pleasant experience for you, while providing you with the best dental treatment.

Our practice is prevention-oriented, and your first visit with us will include a comprehensive examination and all x-rays needed to diagnose the condition of your mouth. In most instances, your diagnosis will be determined at this visit, and, if needed, recommendations for treatment will be discussed with you.

*Your time is important to us, and, except for emergency situations, you can expect us to be on time for your appointment. We appreciate the same from our patients, and expect at least 24 hours' notice for appointment cancellation, which will allow us to schedule your reserved time to another patient in need.*

We have enclosed the forms that will be needed for your first visit. Please review and bring the completed forms to your appointment. For your convenience, we have included an appointment card in this packet.

If you have dental benefits, please bring your card and benefit information, so we may file to your **PPO** insurance company. Please do not hesitate to call us prior to your appointment if you have any questions. Again, thank you for choosing our office. We look forward to a lifetime of continuing care.

# *Joshua M. Ferraro D.D.S.*

## Patient Registration

*Information will be held in the strictest of confidence.*

| | |
|---|---|
| **Patient Name** | **Date** |
| **Address** | **Preferred Name** |
| **City, State, Zip** | **S.S.** |
| **Male ___ Female ___ Single ___ Married ___ Minor ___ Widow ___** | **D.O.B. Age** |
| **Employer/School** | **Home Phone** |
| **Address** | **Work Phone** |
| **City, State, Zip** | **Cell Phone** |
| **Occupation** | **E-Mail** |
| **Referred by:** | **Notes:** |

| |
|---|
| Person responsible for account: Relation: |

| **Your Spouse** | **Dental Insurance** |
|---|---|
| **Name** | **Policy Holder** |
| **D.O.B.** | **Relation to Patient** |
| **S.S.** | **Insurance Co.** |
| **Employer** | **Group# ID#** |
| **Work Phone** | **Phone** |
| **Emergency Contact** | **Secondary Insurance** |
| **Name** | **Policy Holder** |
| **Relationship** | **Insurance Co.** |
| **Phone 1:** | **Group# ID#** |
| **Phone 2:** | **Phone** |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Kelley L. Borders D.M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

# *Joshua M. Ferraro D.D.S*

## Medical and Dental History

**Name:** _____ **DOB:** _____ **Today's Date:** _____

Are you under a physician's care now? Yes No Doctor's Name: _____

Phone: _____

Have you ever been hospitalized? Yes No Reason: _____

Have you had a major operation? Yes No What Type: _____

Have you had a serious head or neck injury? Yes No When: _____

Are you taking any medications, pills, or drugs? Yes No: If yes, please list the medications, pills, or drugs:

| | | |
|---|---|---|
| | | |
| | | |
| | | |

Have you ever taken Phen-Fen or Redux? Yes No When: _____

Have you ever taken bisphosphonates? Yes No When: _____
(Fosamax, Boniva, Actonel, Zometa)

Are you on a special diet? Yes No Reason: _____

Do you use tobacco? Yes No Type/Amount: _____

Do you use controlled substances? Yes No Type/Amount: _____

## Dental History

Are you happy with your past dental visits? Yes No If no, Why? _____

Do you have any fear of dental work? Yes No Please Circle: Slight Moderate Severe

Do your gums bleed when brushing or flossing? Yes No

Do you feel you have bad breath? Yes No

Would you like your teeth to be whiter? Yes No

Do you have trouble opening or closing your jaw? Yes No Please Circle: Opening Closing

Would you like to improve your smile? Yes No If yes, How? _____

*Have you ever had braces?* Yes No

When was your last dental cleaning? _____

Have you ever had a reaction to any dental anesthetic? Yes No If yes, What? _____

How did you hear about our office? (Please Circle)

Online Search Website / Insurance Walk-in/Drive By

Friend / Family: _____ Other: _____

*Joshua M. Ferraro D.D.S.*

**Medical and Dental History**

## Medical History

(Women Only) Are you Pregnant/Trying to get Pregnant? ____ Nursing? ____ Taking oral contraceptives? ____

***Circle*** *if you are* ***Allergic*** *to any of the following:*

| | | | |
|---|---|---|---|
| Aspirin | Penicillin/Amoxicillin | Codeine | Acrylic |
| Metal | Latex | Sulfa Drugs | Local Anesthetics |

Please List any other Allergies: _____

***Circle*** *if you have any of the following* ***Medical Concerns:***

| | | | |
|---|---|---|---|
| AIDS/HIV positive | Hepatitis A | Hepatitis B or C | Drug Addiction |
| Herpes/Cold Sores | Diabetes | Excessive Thirst | Swelling of Limbs |
| Shingles | Recent Weight Loss | Sinus Troubles | Frequent Cough |
| Breathing Problems | Easily Winded | Asthma | Anemia |
| Excessive Bleeding | Blood Transfusion | Emphysema | Lung Disease |
| Thyroid Disease | Parathyroid Disease | Liver Disease | Stomach Disease |
| Sickle Cell Disease | Alzheimer's Disease | High Blood Pressure | Low Blood Pressure |
| High Cholesterol | Scarlet Fever | Hypoglycemia | Hemophilia |
| Renal Dialysis | Anaphylaxis | Epilepsy or Seizures | Angina |
| Rheumatic Fever | Rheumatism | Tuberculosis | Yellow Jaundice |
| Kidney Problems | Osteoporosis | Artificial Heart Valve | Mitral Valve Prolapse |
| Tumor or Growths | Congenital Heart Disorder | Heart Murmur | Heart Pacemaker |
| Heart Attack/Failure | Irregular Heartbeat | Leukemia | Cancer |
| Radiation Treatments | Chemotherapy | Fainting Spells/Dizziness | Stroke |
| Psychiatric Care | Bruise Easily | Glaucoma | Frequent Headaches |
| Arthritis/Gout | Chest Pains | | |

Do you have a medical concern not listed? Please explain: _____

Additional comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X_____ Date: _____

# *Joshua M. Ferraro D.D.S.*

## HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("Authorization")

By signing this Authorization, you agree to the release of your Protected Health Information[1] as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA[2] Privacy Rule.[3] If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

**Our Dental Practice contact information:**

| | |
|---|---|
| Dental Practice Name: | Joshua M. Ferraro DDS |
| Privacy Official for Dental Practice: | Joshua M. Ferraro DDS |
| Dental Practice mailing address: | 1708 S. Alexander St.<br>Plant City, FL 33563 |
| Dental Practice email address: | office@bordersdental.com |
| Dental Practice phone number: | 813-752-5600 |

**Your contact information (please complete):**

| | |
|---|---|
| Patient name | |
| Patient mailing address | |
| Patient email address (Optional) | |
| Patient phone number | |

**Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):**

I authorize the Dental Practice named above to release the following Protected Health Information:

___ Dental image(s)

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1 "Protected Health Information" is information (i) about your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies you directly or indirectly *(i.e.*, there is a reasonable basis to believe that the information could be used to identify you); and (iii) that is maintained or transmitted by the Health Plan.

2 "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.

3 The "Privacy Rule" refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA.

**Your rights with respect to this Authorization:**

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

_____ _____

Patient Signature Date

OR

_____

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other:_____

# *Joshua M. Ferraro D.D.S.*

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*Joshua M. Ferraro DDS*

* You May Refuse to Sign This Acknowledgment*

**I have read or received a copy upon request of this office's Notice of Privacy Practices.**

Print Name: _____

Signature: _____

Date: _____

PLEASE LIST ANYONE WE MAY DISCLOSE YOUR PERSONAL HEALTH INFORMATION

_____ Relationship: _____

_____ Relationship: _____

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

**Dr. Joshua M. Ferraro**
1708 South Alexander Street
Plant City, FL 33563
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# 24 HOUR APPOINTMENT CANCELLATION POLICY

Joshua M. Ferraro D.D.S. has a 24-hour cancellation/rescheduling policy.

**If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged $25.**

Cancellations with less than 24 hours' notice are difficult to fill. This office is a private practice dental office, and your appointment time is reserved for your treatment. If you do not provide adequate notice, you are preventing another patient from receiving care during your appointed time.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Joshua M. Ferraro D.D.S., as described above.

Thank you for your understanding and cooperation.

_____ _____

Printed Name Signature

_____

Date

# Email and Text Messaging Program Patient Information Form

We provide our patients the option to participate in our online patient communication system.

Some of the system features allow you the ability to:

- Request Appointments via Email
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Customer Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email, or by replying to a text message with 'STOP'. Standard text messaging rates apply.

## Please Update Your Contact Information

Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____ ☐ **Opt in to text messages**

Email: _____ ☐ **Opt in to email**

Please sign below to indicate that you agree to allow us to use this information in providing your services.

_____

Signature Date

**Joshua M. Ferraro D.D.S.**
1708 South Alexander Street
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# FINANCIAL POLICY

**Please take a moment to read the following information regarding our financial policy.**

- All patients must complete required forms prior to receiving treatment.
- We accept cash, check, any of the major credit cards (Visa, MC, American express, Discover), or Care Credit at the time dental treatment is provided.
- Minors must be accompanied by a parent or guardian unless prior arrangements have been made and the parent or guardian has accepted treatment on the minor's behalf in advance. The person who accompanies a minor/child to the appointment will be considered the responsible party and, therefore, is responsible for any payment due at the time service is rendered.

Dental Insurance

- As a courtesy for our patients with dental insurance, we will help you estimate how much you can expect your insurance to pay, and we will submit your claim to your dental insurance company. We can file most insurances, including PPO plans. WE DO NOT ACCEPT ANY HMO PLAN.
- Any portion not expected to be covered by your insurance is your responsibility and is **due at the time treatment is provided**. This includes deductibles and co-payments.
- Please understand that we cannot predict exactly how much your insurance company will pay and there is no guarantee of any payment by them. If after 90 days your insurance company has not paid its portion, the patient will be responsible for paying the balance in full.
- If you or your family exceed the annual limitations in any plan year, you will be responsible for the full amount of dental services. **The patient is responsible for any charges that are not covered by your insurance.**
- Please remember that we provide dental care to you, our patient, not the insurance company. If you have any questions regarding your insurance benefits, please don't hesitate to call our office to discuss your concerns.
- If you have secondary insurance, we will gladly provide the information you need to file the claim so that you can be reimbursed by your secondary insurance carrier. Being a small office, we cannot carry open balances while waiting for the second insurance payment. The patient is responsible for any amounts the secondary insurance may pay in addition to portions not covered by primary insurance.
- Pre-treatment estimates are not automatically filed, but we are happy to send one at the patient's request.
- Insurance companies say they will cover "Usual and Customary" (UCR) fees. However, most insurances have failed to keep their UCR fee schedules up to date. We are committed to keeping our fees as low as possible so that our patients can afford the treatment they need. If our fee differs from your insurance 'UCR' fee, you are responsible for the difference.

- If you have dental benefits, please bring your card and benefit information, so we may file to your insurance company. We work with most insurance, but **HMO plans are not accepted**, nor can we file a claim for an HMO policy. Please do not hesitate to call us prior to your appointment if you have any questions. Again, thank you for choosing our office. We look forward to a lifetime of continuing care.

Additional Information

- Accounts unpaid for 90 days from date of service are subject to monthly late fees ($35 per month) and finance charges (1.5% monthly).
- If your account is 90 days past due, you may be sent to a collection agency and you will be responsible for any additional collection fees.
- Missed appointments and cancellations with less than 24 hrs notice are subject to a cancellation fee of $25.
- Payment returned to us from your bank due to insufficient funds are subject to a $40 NSF fee.

_____ _____

Signature of Patient or Parent/Guardian Date