Florida Health Care Plans

An Independent Licensee of the Blue Cross and Blue Shield Association

DENTAL CLINIC

FLORIDA HEALTH CARE PLANS

Med. Rec. #: ___________________________

Date: ___________________________

Phone: ___________________________

Name: ___________________________ Cell Phone: ___________________________

Address (Street Address/Apt. #): ___________________________

City/State/Zip: ___________________________

Employer: ___________________________ Business Phone: _______________ Extension: ___________

Occupation: ___________________________ Height: ________ Weight: _________ Date of Birth: _______________

If married please list spouse's name and work phone number:

___________________________ Business Phone: _______________ Extension: ___________

In case of emergency call:

___________________________ Phone: ___________________________

If you are completing this form for another person, what is your relationship to that person?

____

PLEASE ANSWER EACH QUESTION: CIRCLE ONE:

1. Have you ever been diagnosed as having cancer? Yes No
   If yes, area of body: ___________________________ Date Diagnosed: _______________
   Type of treatment: (circle treatment) X-ray, Surgery, Chemotherapy, Medicine
2. Have you been a hospital patient during the past 2 years? Yes No
   If yes, please explain: ___________________________
3. Have you been under a physician's care during the past 2 years? Yes No
   If yes, please explain: ___________________________
4. Are you taking any kind of medicine regularly or at this time? Yes No
   If yes, please list: ___________________________
5. Are you allergic to any drugs or medicine? Yes No
   If yes, please list: ___________________________
6. Have you ever had excessive bleeding requiring special treatment? Yes No
7. CIRCLE any of the following which you have had now or have had in the past. If yes, please list year.

heart trouble	jaundice	arthritis	HIV Positive
heart problems or defect from birth	asthma	stroke	pins in joints
heart murmur	anemia	diabetes	joint replacements or implants
persistent cough	tuberculosis	epilepsy	mitral valve prolapse
high blood pressure	hepatitis	sinus trouble	latex allergy
psychiatric treatment	rheumatic fever	AIDS	Other _______________

8. Have you had any other serious illnesses? Yes No
   If yes, what? ___________________________
9. (Women) Are you pregnant now? Yes No
10. Are you ill today? Yes No
11. Have you ever taken any osteoporosis medications, such as Fosamax, Actonel, Boniva, Reclast, Prolia or Xgeva? Yes No

COMMENTS:

Reviewed by. ___________________________ Patient Signature: ___________________________

(If under 18, Parent or Guardian must sign.)

FHCP 2533 - 10/05
05-735/ 9-05RP
FHCP - 26 - Revised 03-30-17

DENTAL OFFICE
FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

Florida Health Care Plans Medical Billing Department is responsible for processing the billing for dental services rendered to you. If you have a balance due for dental services rendered, you will receive a statement from Florida Health Care Plans.

If you do not have insurance or do not want us to submit your charges to your insurance company, full payment is due at time of service. We accept cash, checks, debit and credit cards. There will be a charge for each returned check. Balances not paid within 60 days from the date of service may be turned over to a collection agency.

Regarding your insurance:

If the dentist you are seeing is a participating provider under your insurance plan and if the services you are receiving are expected to be covered expenses, we will gladly file your insurance claim for you. You will need to present your current insurance card and provide any additional information that may need to be necessary to file your claim. **You will be required to pay the estimated portion of the bill that you will be responsible for at the time of service. Upon receipt of remittance from your insurance company, the remaining account balance will be transferred to your responsibility. You will receive a statement at that point detailing the charges due. This statement balance will be due immediately. Balances that are not paid within 60 days from the statement date may be forwarded to collection.**

We are committed to providing the best treatment for our patients and our charges are based on what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Each appointment you make is customized for you and our staff starts preparing for your appointment the previous day .On the day of your appointment the office is staffed depending on your appointment needs. Please give at least 24 hours advance notice when cancelling or changing appointments. Due to the preparation that takes place for your appointment failure to notify less than 24 hours will result in you being charged a cancellation fee up to in full for the appointment.

Thank you for understanding our financial policy. If you have any questions or concerns, please speak with a member of our staff or contact the billing office at 386-676-7124.

I have read the financial policy and understand and agree to this financial policy.

Signature of Patient or Responsible Party Date