Welcome To the Office Keith Blessitt, D.M.D., P.A.
Aesthetic Comprehensive Dentistry

About You

Date: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Birthdate: __/___/___ SS#_____ Gender: O M O F Status: O M O S O D O W

Driver's License#:_____ State: _____Valid Thru: _____

Home Phone#_____ Cell Phone# _____ Work Phone#_____

E-mail address (e-mail info is for office use only) _____

Employer: _____ Position: _____ Student? O Y O N Where? _____

Work Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Spouse's Name: _____ Spouse's Place of Employment: _____

Person Responsible for Account (if child, parent or guardian name): _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____ Country: _____

Emergency Contact

Name of contact: _____Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Country:_____

Emergency Contact Phone Number: _____

Who may we thank for your referral to our office? _____

Keith Blessitt, DMD,PA

Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◌ Yes ◌ No If yes

Have you ever been hospitalized or had a major operation? ◌ Yes ◌ No If yes

Have you ever had a serious head or neck injury? ◌ Yes ◌ No If yes

Are you taking any medications, pills, or drugs? ◌ Yes ◌ No If yes

Do you take, or have you taken, Phen-Fen or Redux? ◌ Yes ◌ No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◌ Yes ◌ No If yes

Are you on a special diet? ◌ Yes ◌ No

Do you use tobacco? ◌ Yes ◌ No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances? ◌ Yes ◌ No If yes

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◌ Yes ◌ No	Cortisone Medicine ◌ Yes ◌ No	Hemophilia Yes ◌ No	Radiation Treatments ◌ Yes ◌ No
Alzheimer's Disease ◌ Yes ◌ No	Diabetes ◌ Yes ◌ No	Recent Weight Loss Yes ◌ No	Anaphylaxis ◌ Yes ◌ No
Drug Addiction ◌ Yes ◌ No	Hepatitis A, B or C ◌ Yes ◌ No	Renal Dialysis Yes ◌ No	Anemia ◌ Yes ◌ No
Easily Winded ◌ Yes ◌ No	Herpes ◌ Yes ◌ No	Rheumatic Fever ◌ Yes ◌ No	Angina ◌ Yes ◌ No
Emphysema ◌ Yes ◌ No	High Blood Pressure ◌ Yes ◌ No	Rheumatism ◌ Yes ◌ No	Arthritis/Gout ◌ Yes ◌ No
Epilepsy or Seizures ◌ Yes ◌ No	High Cholesterol ◌ Yes ◌ No	Scarlet Fever ◌ Yes ◌ No	Artificial Heart Valve ◌ Yes ◌ No
Excessive Bleeding ◌ Yes ◌ No	Hives or Rash ◌ Yes ◌ No	Shingles ◌ Yes ◌ No	Artificial Joint ◌ Yes ◌ No
Excessive Thirst ◌ Yes ◌ No	Hypoglycemia ◌ Yes ◌ No	Sickle Cell Disease ◌ Yes ◌ No	Asthma ◌ Yes ◌ No
Fainting Spells/Dizziness ◌ Yes ◌ No	Irregular Heartbeat ◌ Yes ◌ No	Sinus Trouble ◌ Yes ◌ No	Blood Disease ◌ Yes ◌ No
Frequent Cough ◌ Yes ◌ No	Kidney Problems ◌ Yes ◌ No	Spina Bifida ◌ Yes ◌ No	Blood Transfusion ◌ Yes ◌ No
Frequent Diarrhea ◌ Yes ◌ No	Leukemia ◌ Yes ◌ No	Stomach/Intestinal Disease ◌ Yes ◌ No	Breathing Problems ◌ Yes ◌ No
Frequent Headaches ◌ Yes ◌ No	Liver Disease ◌ Yes ◌ No	Stroke ◌ Yes ◌ No	Bruise Easily ◌ Yes ◌ No
Genital Herpes ◌ Yes ◌ No	Low Blood Pressure ◌ Yes ◌ No	Swelling of Limbs ◌ Yes ◌ No	Cancer ◌ Yes ◌ No
Glaucoma ◌ Yes ◌ No	Lung Disease ◌ Yes ◌ No	Thyroid Disease ◌ Yes ◌ No	Chemotherapy ◌ Yes ◌ No
Hay Fever ◌ Yes ◌ No	Mitral Valve Prolapse ◌ Yes ◌ No	Tonsillitis ◌ Yes ◌ No	Chest Pains ◌ Yes ◌ No
Heart Attack/Failure ◌ Yes ◌ No	Osteoporosis ◌ Yes ◌ No	Tuberculosis ◌ Yes ◌ No	Cold Sores/Fever Blisters ◌ Yes ◌ No
Heart Murmur ◌ Yes ◌ No	Pain in Jaw Joints ◌ Yes ◌ No	Tumors or Growths ◌ Yes ◌ No	Congenital Heart Disorder ◌ Yes ◌ No
Heart Pacemaker ◌ Yes ◌ No	Parathyroid Disease ◌ Yes ◌ No	Ulcers ◌ Yes ◌ No	Convulsions ◌ Yes ◌ No
Heart Trouble/Disease ◌ Yes ◌ No	Psychiatric Care ◌ Yes ◌ No	Venereal Disease ◌ Yes ◌ No	Yellow Jaundice ◌ Yes ◌ No
Sjogrins ◌ Yes ◌ No	Vertigo ◌ Yes ◌ No		

Have you ever had any serious illness not listed above? ◌ Yes ◌ No If yes

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Keith Blessitt, D.M.D., PA.
2420 Tamiami Trail Suite B
Nokomis, FL 34275
(941)-966-7226

Our Financial Policy

Thank you for choosing us as your health care provider. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We are committed to your treatment being successful. 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 you read and sign prior to any treatment.

FULL PAYMENT OF YOUR PORTION IS DUE AT THE TIME OF SERVICE. A DEPOSIT IS REQUIRED FOR ANY LONGER OR EXTENSIVE TREATMENTS. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS AND CARECREDIT.

Past Due Accounts:
If payment is not received by the due date printed on the statement, then your account is considered past-due. We reserve the right to charge 1.5% per month, billing charge on all past due accounts. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or attorney for collection, the account holder will be responsible for all attorney and/or collection fees. We reserve the right to dismiss you as a patient if your account is referred to a collection agency or attorney.

Adult Patients:
Adult patients are responsible for payment at the time of service (if insurance is applicable you must pay your portion and deductible).

Minor Patients:
The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless a payment arrangement has been made.

***We reserve the right to charge for missed or broken appointments with less than 48 hours notice.**

I understand (patient or legally responsible party), authorize dental treatment to be rendered by the dentist and his staff, and I assume all financial responsibility for treatment given, rendered and all associated costs incurred as a result of any treatment.

I have read and agree to the policies outlined above.

Signature of patient or responsible party	Date	Relationship to patient

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Patients with Dental Insurance Only:
As a courtesy to you, our office will gladly submit to your insurance company. We are able to bill to most traditional PPO plans. However, we do require your percentage of the bill be paid to our office at the time of services. We can only estimate insurance payments, and do not guarantee payment. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Insurance companies provide us with an estimate for services, which are not a guarantee of payment. WE ARE AN OUT OF NETWORK PROVIDER.

INITIAL: _____

Dental Insurance

#1 Primary Insurance Information

Insurance Carrier Name: _____ Phone# _____
Name of Insured: _____ D.O.B._____
Insured I.D. # _____ Group #_____

#2 Secondary Insurance Information

Insurance Carrier Name: _____ Phone# _____
Name of Insured: _____ D.O.B._____
Insured I.D. # _____ Group #_____

I authorize my insurance company to pay my dental benefits directly to the office of Keith Blessitt, D.M.D.,P.A.

_____ _____
Signature **Date**

Payment Options: Cash, Check, Visa, MasterCard, American Express, Discover, CareCredit

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Photography, video, images and testimonials

As a part of your diagnosis and care we routinely record images of your smile and other dental conditions. Some of these images may be used for professional lectures, study, training, research and promotion. Would you allow us to use your image without your name, for dental health diagnosis, smile imaging, patient education, publication, research, promotion and professional lectures?

_____Y _____N

I consent and authorize Keith Blessit, D.M.D., P.A. to use my image and testimonial letter, without my name, for dental health diagnosis, smile imaging, patient education, publication, research, promotion and professional lectures and/or any other lawful purpose and I release and forever discharge him from any claim, demands and/or liability on account of such use or for the quality of the image reproduction or text.

_____ _____

Signature of patient or responsible party **Date**

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand as part of treatment, payment or healthcare operations it may become necessary to disclose health information to companies for payment. I understand this information serves as:

- A basis for planning my care and future treatment
- A means of communication among healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and treatment to my bill
- A means by which a third party can verify that services billed were actually provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided with a "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures of my health information. I have reviewed the HIPAA Policy notice available for the office of Dr. Keith Blessitt.

Do we have your permission to:

Send appointment reminders to your home Y____ N____

Call you at home or leave the following information on your home answering machine/voice mail/cell phone:

Appointment information Y____ N____
Billing information Y____ N____
Medical information Y____ N____

Call you at work or leave the following information on your work answering machine/voice mail:

Appointment information	Y____ N____
Billing information	Y____ N____
Medical information	Y____ N____

I give permission to share appointment, treatment, and payment information with the persons name below: Example: Spouse (name), children (name), Friends/caregiver (name),

Name: _____

I fully understand and accept/decline (please circle one) the information of this consent.

_____ _____
(Print name) (Date)

_____
(Signature)

THIS AREA FOR OFFICE USE ONLY

- Individual refused to sign
- Communication barriers prohibited obtaining consent
- Patient chose not to keep copy
- Other_____

_____

_____