Keith Blessitt DMD, PA
We Make Smiles
Cosmetic, Implant, Restorative

Welcome to the Office of
Keith Blessitt DMD, PA
Aesthetic Comprehensive Dentistry

About You

Date: _____

Name: _____Nick Name:_____ Last Name: _____

Address: Street:_____

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

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

Birthdate: __/___/___ **SS#:** _____-____-_____ **Gender:** ❑ Male ❑ Female **Status:** ❑ S ❑ M ❑ D ❑ W

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

E-mail address (for office use only):_____

Employer: _____ **Occupation:** _____ **Student:** ❑Y ❑N Where? _____

Work Address: Street:_____

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

In Case of Emergency, who should be notified? _____

Relationship to Patient: _____Cell Phone:_____Home:_____

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

2420 TAMIAMI TRAIL NORTH SUITE B NOKOMIS FL 34275
941.966.7226 * info@nokomisdentist.com

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OUR FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is part of your treatment. Everyone benefits when office and financial policy arrangements are understood. ***The following is our policy:***

Payment is due at the time service is provided. We accept cash, personal checks, debit cards, money orders, Visa, Mastercard and Discover. Outside financing is available through Care Credit upon request and approval. Returned checks will be subject to a fee, and any future checks will not be accepted thereafter. Patients that receive the checks from the insurance company are required to provide us with a credit card with authorization to bill your account for the amount paid to you by the insurance company.

Dental Insurance: Our office is out -of-network (non-participating) for all insurance companies. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services regardless of dental insurance. It is your responsibility to ensure that the insurance information we have on file is accurate. We have no way of knowing when/if your insurance coverage changes. We will help you process all your insurance claims. However, it is your obligation to familiarize yourself with your insurance coverage as benefits vary and not all services are covered. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Once the insurance has paid their share, the unpaid balance becomes your responsibility.

Usual and Customary Rates: Frequently, insurance companies state that the reimbursement was reduced because the dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a service. This can be very misleading and simply not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processed. The insurance company then takes this data and chooses a level they call the "allowable" UCR fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit. Our office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. You are responsible for the payment regardless of any insurance company's determination of usual and customary rates.

Treatment Plan: Please understand that we will provide a treatment plan estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits determine the amount paid.

Finance charge: We reserve the right to charge interest in the amount of 1.5% per month. Balances older than 90 days will be subject to this rate.

Cancellation & Late Policy: If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We understand that emergencies may arise that preclude you from keeping an appointment, but as our office strives to treat patients in a timely manner, we expect the courtesy to be returned. For cancellations we require 24-hour advanced notice, to avoid a possible cancellation fee due to the inconvenience caused to the office. Your early cancellation will give another patient the opportunity to have access to timely dental care. An answering machine is available for messages left after business hours.

Missed Appointments: A failure to present at the time of a scheduled appointment will be recorded in the patients' chart and we reserve the right to assess a broken appointment fee. Patients with frequent no-shows or cancellations may be dismissed from the practice.

We thank you for the opportunity to serve your dental health and welcome any questions you may have concerning your care or our policies.

Consent: I have read, understand, and agree to the above terms and conditions and have had any and all questions answered to my satisfaction. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that I am financially responsible for any and all charges for dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature:_____ Date:_____

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MEDICAL HISTORY

Patient Name:_____ Birth Date:_____

Address:_____

Cell Phone: _____ Phone: _____ Email: _____

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 currently being seen or treated by a physician? ❑ Yes ❑ No If yes: _____

*Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?* ❑ Yes ❑ No

*Have you had a **serious illness, operation or hospitalized** in the past 5 years?* ❑ Yes ❑ No If yes: _____

*Have you had any type **(total/partial) of joint replacement** (such as hip, knee, shoulder, elbow, etc.)?* ❑ Yes ❑ No If yes:_____

Have you had a **heart valve replacement or heart surgery***?* ❑ Yes ❑ No If yes, when _____

*Have you had an **organ or bone marrow/stem cell transplant**?* ❑ Yes ❑ No If yes, when _____

*Have you ever had a **serious head or neck injury?*** ❑ Yes ❑ No If yes, when_____

*Are you taking any **medications (RX), over-the-counter medicine(s), vitamins, herbs and/or supplements**?* ❑ Yes ❑ No If yes: _____

_____

_____

*Do you use **controlled substances** (drugs, including marijuana, for either medicinal or recreational reasons)?* ❑ Yes ❑ No

*Are you taking any **blood thinners ?*** ❑ Yes ❑ No If yes: _____

*Are you taking any medications to treat **osteoporosis** or Paget's Disease?* ❑ Yes ❑ No

Some commonly-prescribed drugs include alendronate (**Fosamax),** risedronate(**Actonel**), ibandronate (**Boniva),** zolendronate (**Reclast**) and denosumab (**Prolia**) ❑ Yes _____

Do you use tobacco, nicotine, vaping products (cigarettes, cigars, snuff, chew, bidis)? ❑ Yes ❑ No If yes: _____

Women: Are you…. ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐Taking oral contraceptives ☐ Hormone Replacement

Are you **ALLERGIC** or **SENSITIVE** to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑Acrylic ❑Metal ❑Latex ❑Sulfa Drugs

❑ Local Anesthetics Other? If yes _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

AIDS/HIV Positive	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Anaphylaxis	☐ Yes	☐ No
Hepatitis A,B,or C	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Artificial Joint	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Blood Transfusion	☐ 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	Low Blood Pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Mitral Valve Prolapse	☐ 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
Heart Pacemaker	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Sjogren	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No

Have you ever had any serious illness not listed above? If yes, explain _____

NOTE: It's important for both the doctor, staff and patient to talk honestly about the patient's health before dental treatment starts. To the best of my knowledge, I have answered the above questions completely, accurately and to the best of my ability. 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/Legal Guardian: _____ Date: _____

Patients with Dental Insurance Only

As a courtesy to you, our office will gladly submit it 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.

Patient Name (print):_____

Patient Signature:_____ Date:_____

Payment Options:

- Cash
- Check
- Visa, MasterCard, Discover, American Express
- Financial Plans through Care Credit Financing

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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. 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?

❑ Yes ❑No

I consent and authorize Keith Blessitt, 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.

Patient Name (print):_____

Patient Signature:_____ 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 provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided with "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? ❑Yes ❑No

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

Appointment information	❑Yes	❑No
Billing information	❑Yes	❑No
Medical information	❑Yes	❑No

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

Appointment information	❑Yes	❑No
Billing information	❑Yes	❑No
Medical information	❑Yes	❑No

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

Name: _____

I fully understand and ❑ accept ❑ decline (please mark box) the information of this consent.

Patient Name (print):_____

Patient Signature:_____ Date:_____

THIS AREA FOR OFFICE USE ONLY

❑ Individual refused to sign
❑ Communication barriers prohibited obtaining consent
❑ Patient chose not to keep copy
❑ Other _____

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