Raymond A. Della Porta, D.M.D., P.A & Raymond A. Della Porta II, D.M.D., P.A.
Patient Information

Patient Name: _____ **Date**: _____
Last, First MI (Preferred Name)

Gender: _____ **Marital Status**: _____

Social Security #: _____ **Birth Date**: _____

Phone (Home): _____ **(Work)**: _____ **Ext**: _____ **Mobile**: _____

Summer Home: _____ **Best time to call**: _____

E-Mail Address: _____

Preferred appointment times: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Any Time** ☐**M** ☐**T** ☐**W** ☐**T** ☐**F** ☐**S**

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ **Reason for this visit**: _____

Do you have or have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Alzheimer's Disease
☐ Anemia
Arthritis
☐ Rheumatoid
☐ Osteoarthritis
☐ **Artificial Joints**
Date Placed: _____
☐ Asthma
☐ Autoimmune Disease:
_____
☐ Blood Disease
☐ Cancer
Type:_____
☐ Diabetes
Type: _____
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Heart Disease
☐ Heart Murmur
☐ Heart Stents
☐ **Heart Valve Replacements**
☐ Hepatitis (A/B/C)
☐ Herpes
☐ HIV
☐ Defibrillator
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Multiple Sclerosis
☐ Nervous Disorders
☐ Pacemaker
☐ Parkinson's Disease
☐ WOMEN: Pregnant?
☐ Radiation Treatment
Type: _____
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoking
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ **Codeine** Allergy
☐ **Penicillin** Allergy
☐ **Sulfa** Allergy
☐ **Sulfite** Allergy
☐ Other:
_____
_____
_____
_____

BLOOD THINNERS
☐ **Aspirin**
☐ **Coumadin/Warfarin**
☐ **Eliquis**
☐ **Plavix**
☐ **Xarelto**
☐ **Fish Oil**

- **Have you ever been told to pre-medicate prior to dental treatment**? ☐ Yes ☐ No
- **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 medical physician?** ☐ Yes ☐ No
  If yes, please explain: _____
- **Name of Physician**: _____ **Phone**: _____
- **Are you taking any medications at this time**? ☐ Yes ☐ No
  If yes, please list: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient _____
☐ Yellow Pages ☐ Newspaper ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient:_____ **Date**: _____

Responsible Party for Payment Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other** _____

Social Security #: _____ **Birth Date**: _____

Phone (Home): _____ **(Work)**: _____ **Ext**: _____ **Best time to call**: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ **Occupation**: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ **Is insured a patient?** ☐ **Yes** ☐ **No**
Last First MI

Insured's Birth Date: _____ **ID #**: _____ **Group #**: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ **Is insured a patient?** ☐ **Yes** ☐ **No**
Last First MI

Insured's Birth Date: _____ **ID #**: _____ **Group #**: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date**: _____ **Relationship to Patient**: _____
Signature of patient, parent or guardian

_____ Date: _____ **Relationship to Patient**: _____
Signature of guarantor of payment/responsible party

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** _____

Release of Information

[ ] I authorize the release of Information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

Phone #_____

[ ] Child(ren) _____

Phone #_____

[ ] Other _____

Phone #_____

[ ] Information is not to be released to anyone.

The ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please Call: [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is *(day)* _____ between *(time)* _____

Signed: _____ Date: ___/___/_____

Witness: _____ Date: ___/___/_____

DellaPorta Cosmetic Dentistry

Raymond A. Della Porta II, DMD, PA

Please read The following Payment Policies before your appointment.

Our office files your insurance as a "courtesy".

If your Doctor is an in-network provider for your insurance,

YOUR ESTIMATED PATIENT PORTION MUST BE PAID AT THE TIME OF SERVICE

ALL DEDUCTIBLES ARE DUE AT THE TIME OF YOUR VISIT

Please note – Each insurance policy is different. It is your responsibility to know your policy. If pre-authorization is needed, then it is your responsibility to notify our staff so we may obtain authorization. If authorization is not obtained, it is your responsibility to pay for all charges incurred. Remember, your insurance policy is a contract between you and your insurance company. It is not a contract between you and our Doctors. In order for us to process your insurance, we must have a copy of your card. It is also your responsibility to let us know if there is a change in your insurance information.

If you have any questions or are not prepared to pay for your appointment, please notify one of our office staff prior to your appointment. If you are unable to pay for residual balances from previous dates of service you may be asked to reschedule your appointment.

There is a $35 charge for NSF checks.

We do not participate in any HMO, Medicare, Medicaid, ACA, or Discount plans.

***CareCredit is offered for any treatment over $300, our staff is glad to assist you with the application.**

_____ _____

Patient Name (Printed) Date

_____

Patient Signature

1300 36th Street, Suite F, Vero Beach, FL 32960 * Tele 772.567.1025 * Fax 772.778.6597
admin@drdellaporta.com

Credit Card on File Authorization

Please complete this form for ***Della Porta Cosmetic Dentistry*** to keep your credit card on file. You may elect to provide us with a separate payment method at each visit; however we do require you to keep a credit card on file for unpaid balances. We will NEVER charge your card without attempting contacting you first.

Information to be completed by the card holder:

Cardholder Name: _____

Card Number: _____

Card Type: Visa* MasterCard* American Express *Discover* Care Credit

Expiration Date: _____

Security Code: (3 digit code on back) _____

Billing Zip Code: _____

I, _____, authorize ***Della Porta Cosmetic Dentistry*** to charge the above credit card account for payments owed to my account for services rendered at their office that are over 90 days. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

_____

Cardholder Signature Date

Radiograph Request Form

Previous Doctor Name and Number: _____

Please forward most recent radiographs to:

If you have DEXIS can you send them over in DEXIS FORMAT PLEASE!!!

admin@drdellaporta.com
Dr. Raymond Della Porta II, D.M.D., P.A.
1300 36th Street
Suite F
Vero Beach, FL
32960

If you have any questions or concerns, please call our office.
(772) 567-1025

Thank you

Patient Name: _____

Date of Birth: _____

Patient Signature: _____ Date: _____