General & Cosmetic Dentistry

Randall A. Diez, DMD, PA

Date_____

PATIENT INFORMATION

Name: Dr. / Mr. / Mrs. / Ms. _____ Email: _____
Last First Middle

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____ SS#: _____

Spouse/ Parent Employer: _____ Date of Birth: _____

Dental Insurance: _____ Name of Policyholder: _____ ID#: _____

Who Referred You To Us? _____

Previous Dentist / Address _____ Phone: _____

MEDICAL HEALTH

Physician's Name: _____ Phone: _____

Physician's Address: _____

Last Physical: _____ Findings: _____

Emergency Contact: _____ Phone: _____

Are you presently taking any medications? ❑ Yes ❑ No Type/Purpose _____

Are you allergic to any medications? ❑ Yes ❑ No If so, please list _____

Do you have, or had any of the followings:

	Yes	No		Yes	No
Heart Disease	❑	❑	Are you a smoker or ever been?	❑	❑
Bacterial Endocarditis	❑	❑	Artificial heart valve or hip	❑	❑
Abnormal Blood Pressure	❑	❑	Hepatitis	❑	❑
Ulcers	❑	❑	Asthma or Hay fever	❑	❑
Tuberculosis or Lung Disease	❑	❑	Sinus Trouble	❑	❑
Diabetes	❑	❑	Arthritis	❑	❑
Epilepsy	❑	❑	Stroke	❑	❑
Blood Disease (Anemia)	❑	❑	Glaucoma	❑	❑
Congenital Heart Lesions	❑	❑	Fainting	❑	❑
Tumor History	❑	❑	Are you pregnant	❑	❑
Autoimmune Disorders	❑	❑	Acquired Immune Deficiency HIV/AIDS	❑	❑
Are you subject to prolonged/excessive bleeding	❑	❑	Radiation Therapy or Chemotherapy	❑	❑

DENTAL HEALTH

Date of last dental exam: _____

What is your immediate dental concern or reason for today's appointment? _____

Do you have any specific questions concerning your health, teeth or gums? _____

Patient Signature _____

General & Cosmetic Dentistry of Tampa

Randall A. Diez, DMD PA
Michael A. Diez, DMD

APPOINTMENTS POLICY

When a dental appointment is made in our office, a specific time is reserved for the patient to see the dentist or hygienist. The appointment allows the dentist to meet the patient's needs and also schedule other equally important patients. Broken appointments result in a loss of valuable time that could be spent with patients in need of treatment, and they are very costly to our office.

For this reason, if a patient fails to keep an office visit, he or she will be charged a fee for a broken appointment.

Because we are not in the position to determine if an excuse is valid or not, **no exceptions** will be made to this policy. It is the patient's ultimate responsibility to keep their scheduled appointment.

If an appointment does need to be cancelled or rescheduled for any reason, please notify our office at least 48 hours in advance of the appointed time and no broken appointment fee will be charged. *Our office does not accept notification of cancellations or requests to reschedule appointments via email or text message.*

We thank you for your anticipated cooperation.

Signed: _____ Date: _____/_____/_____
(Patient/Parent/Guardian)

5010 Gunn Highway, Tampa, FL 33624 Phone: (813)960-5869 Fax: (813)968-7578
Email: DrDiez@mindspring.com Web: www.tampacosmeticdentist.com

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FINANCIAL POLICY

Assignment of benefits may be accepted only after your insurance has been verified and eligibility requirements have been met. We accept assignment of benefits as a courtesy to you. However, *insurance payments are an estimate based on information obtained from your carrier.* There is no guarantee of payment or that they will pay the exact amount estimated. Your estimated co-pay is due at the time of service. Any unpaid balances by the insurance company remain your responsibility. In the event that we are unable to collect on any outstanding insurance claims within 90 days, the balance in full will be billed to you and payment is expected.

We require a credit card number and photo ID to be kept on file as a guarantee of payment in the event the insurance company does not pay the balance in full. We will contact you prior to charging your credit card; contact will be via mail or phone. If you do not have a credit card number we will not be able to accept assignment of benefits. Payment in full is expected in cases where insurance companies will not assign benefits to us but are known to send reimbursements checks directly to the insured. Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. Please be aware that some, and perhaps all, of the service provided may be non-covered and not considered reasonable and necessary under various insurance plans.

Our practice is committed to providing the best treatment for our patients and we charge a fair fee for the high quality of dentistry that we provide. You are responsible for payment regardless of any insurance company's arbitrary determinations of "usual and customary" fees or need for treatment.

I have read, understand and agree to this Financial Policy. I have been given the opportunity to discuss questions or concerns with a member of the staff.

Credit Card Authorization

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover ☐ Care Credit

Cardholder Name _____

Account Number _____ CVV Sec Code _____

Expiration Date _____ Billing Zip Code _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Signature _____ Date _____

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INSURANCE GUARANTEE OF PAYMENT AND FINANCIAL POLICY

Patient Name: _____ DOB: _____

Phone: (H) _____ (W) _____

Name of Insurance Company: _____

IT IS THE POLICY OF THIS OFFICE TO FILE YOUR INSURANCE AS A COURTESY

If payment has not been made by your insurance carrier after your claim has been filed for eight (8) weeks, you will be billed accordingly for these charges. It is then your responsibility to follow up with your insurance company as to the reason no payment has been made. Insurance companies do not guarantee payment on either written or verbal verification. Insurance coverage is a contract between the patient/employer and the insurance company. The dentist does not enter into this contract, thus cannot be responsible for the lack of payment of any assignment. We will be more than happy to assist you whenever possible.

I hereby agree to guarantee and promise to pay the office of General & Cosmetic Dentistry of Tampa – Dr. Randall Diez and Dr. Michael Diez all charges incurred in the treatment of the above named patient including those expenses not covered by any insurance policy presently in force. All deductible amounts and non-covered expenses are to be paid in full within ten (10) days of notification.

If any action of law in equity is brought to enforce this agreement, the office of General & Cosmetic Dentistry of Tampa - shall be entitled to reasonable attorney fees, costs, and any other costs of collections incurred.

Signed: _____ Date: _____/_____/_____
(Patient/Parent/Guardian)

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