4506 N. University Drive
Lauderhill, Florida 33351
Phone: 954-368-7500 Fax: 954-368-7501
info@marinofamilydental.com

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

First Name: _____ Last Name: _____ MI: _____
Home Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone : _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐Single ☐Divorced
☐ Separated ☐ Windowed
Date of Birth: _____ Age: _____
Soc. Sec. #: _____ Driver's Lic. #: _____
E-mail: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insured Soc. Sec. #: _____ Insured Date of Birth: _____

Employer: _____
Office Phone: _____
Address: _____
Apt: _____
City: _____ State: _____
Zip: _____
Employment Status:
☐ Full Time ☐ Part Time ☐ Retired
☐ Student

Primary Insurance: _____
Effective Date: _____
ID #: _____
Group #: _____
Address: _____
City: _____ State: _____
Zip: _____
Phone: _____

RESPONSIBLE PARTY INFORMATION

First Name: _____ Last Name: _____ MI: _____
Home Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone : _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐Single ☐Divorced
☐ Separated ☐ Windowed
Date of Birth: _____ Age: _____
Soc. Sec. #: _____ Driver's Lic. #: _____
E-mail: _____

★Referred By: _____ Patient of Record: ☐ Yes ☐ No

MEDICAL/DENTAL HISTORY

Primary Dr.: _____ Pharmacy: _____
Address: _____ Pharmacy #: _____
_____
Office Phone: _____ Emergency Contact: _____
Previous Dentist: _____ Relation to Patient: _____
Office Phone: _____ Emergency Phone: _____

Are you Allergic to? (check box if yes)
☐ Latex ☐ Novacaine ☐ Penicillin ☐ Codeine ☐ Reaction to Metals ☐ Sulfa
☐ None ☐ Other _____

Are you presently taking any medications (prescription & over the counter)? ☐Yes ☐No
Medication List: _____

Have you recently been hospitalized? ☐ Yes ☐No Date:_____
Reason: _____
List of Surgeries/Dates: _____

Are you pregnant? ☐Yes ☐No How many Months? _____ Do you take oral contraceptives? ☐Y ☐ N

Do you take blood thinning medication? ☐ Yes ☐ No If so, what medication? _____
Do you take oral bisphosphonates (for osteoporosis)? ☐Y ☐ N If so, what medication? _____

Do you currently have or have you had a history of any of the following?

Rheumatic Fever	☐Y ☐ N	High Blood Pressure	☐Y ☐ N
Mitral Valve Prolapse	☐Y ☐ N	Diabetes	☐Y ☐ N
Artificial Heart Valve	☐Y ☐ N	Epilepsy	☐Y ☐ N
Heart Attack (Angina)	☐Y ☐ N	Lung Disease/Asthma	☐Y ☐ N
By-pass surgery/Stent placement	☐Y ☐ N	Fibromyalgia	☐Y ☐ N
Pace Maker	☐Y ☐ N	Arthritis	☐Y ☐ N
Organ Transplant	☐Y ☐ N	Sinus Problems	☐Y ☐ N
Joint Replacement	☐Y ☐ N	Hemophilia (Bleeding)	☐Y ☐ N
Dialysis	☐Y ☐ N	Cancer (Chemo/Radiation)	☐Y ☐ N
Hepatitis B or C	☐Y ☐ N	Kidney Disease	☐Y ☐ N
HIV (AIDS)	☐Y ☐ N	Liver Disease	☐Y ☐ N
Drug Addiction	☐Y ☐ N	Depression/Bipolar	☐Y ☐ N

How long since your last dental visit (Date)? _____ Last Cleaning? _____

Do you have a toothache?	☐Y ☐N
Do you have bleeding or sore gums?	☐Y ☐N
Do you have receding gums?	☐Y ☐N
Do you have teeth sensitive to hot or cold?	☐Y ☐N
Do you have loose teeth?	☐Y ☐N
Do you have missing teeth?	☐Y ☐N
Do you wear dentures (plates) – partial or full? If so, how old are they? _____	☐Y ☐N
Do you have crowded, twisted, or crooked teeth?	☐Y ☐N
Do you have spaces between your teeth that bother you?	☐Y ☐N
Do you have stained or discolored teeth?	☐Y ☐N
Do you smoke?	☐Y ☐N
Do you have dark fillings that show when you smile?	☐Y ☐N
Do you have chipped or cracked teeth?	☐Y ☐N
Do you have existing crowns or dental work that you consider 'ugly" or unsightly?	☐Y ☐N
Are you interested in treatment for reduction/removal of facial wrinkles?	☐Y ☐N
Are you anxious or fearful of dental treatment?	☐Y ☐N

What is the main reason for your dental visit today? _____

_____ _____ _____
Patient Signature (Parent or Guardian) Doctor Signature Date

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GENERAL INFORMED CONSENT

PATIENT NAME: _____

1. **DRUGS AND MEDICATIONS:** I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling to tissues, pain, itching, and/or anaphylactic shock (severe allergic reaction) as well as adverse reactions including drowsiness, nausea, upset stomach, vomiting or diarrhea. I also understand that the use of nitrous oxide "laughing gas" can sometimes cause the adverse side effect of general malaise and nausea.
2. **FILLINGS AND BONDINGS:** I understand that many times, fillings might need further treatment such as root canal treatment, post & core, and crowns if pain persists after completion of treatment. I have been informed that bondings of fractured front teeth is the only attempt prior to crowning of the tooth. I have been provided with at home instructions
3. **CROWNS, BRIDGES AND VENEERS:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I realize the final opportunity to make changes in my new crowns, bridge or veneers (including fit, size, shape, and color) will be before cementation. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. The purpose of a temporary crown is to retain space and prevent the slight movement of adjacent teeth that will not allow the proper fit of the permanent crown. If a temporary crown is lost and off for more than 2 weeks, the permanent crown may have to be remade and the lab charge will be applied.
4. **EXTRACTION OF TEETH:** Alternatives to extractions and treatment options have been explained to me (root canal treatment, crowns, periodontal surgery, bridges, bone grafts, implants, etc.) and I authorize the dentist to extract all teeth on the treatment plan and for any other necessary reasons. I also understand that if taking any prescription blood thinning medication, I will be required to be medically cleared by my general care practitioner prior to undergoing dental extractions due to increased risk of prolonged bleeding. I understand extraction of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having the teeth extracted, some of which are pain, swelling, limited jaw opening (trimus), spread of infection, persistent bleeding, dry socket, bony spicules, loss of feeling in my teeth lips, tongue and surrounding tissue (paresthesia that can last for an indefinite period of time), sinus perforation, and/or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during the needed treatment, the cost of which is my responsibility.
5. **ROOT CANAL TREATMENT:** I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occasionally instruments can separate within the tooth. I have been informed that instrument separation may not necessarily affect the success of treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). Also if I do not return for the follow up visits within a reasonable time frame from the start of treatment, not only can this increase risk of treatment failure, but also the root canal may have to be redone, therefore, incurring the additional out of pocket expense to perform the same procedure for the second time. If pain persists after root canal treatment, extraction, followed by restoration with a bridge or a bone graft and implant placement might be necessary. Furthermore, I have been informed of the need to restore the root canal treated tooth with a crown. I realize that should I neglect to return for proper restoration within one month of completed root canal treatment, there is an increased risk of treatment failure and/or tooth fracture.
6. **PERIODONTAL TISSUE & BONE LOSS:** I understand that if I have a serious condition causing loss of tissue and bone, it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, extractions, and replacements with a removable prosthesis. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. All recall visits should be kept up or the charge of re-treating the area will be incurred. Extraction sites might need bone grafting for future implant placement.

7. **DENTURES-COMPLETE OR PARTIAL:** I realize that complete or partial dentures are artificial, constructed of plastic or metal. The results of wearing these removable prostheses have been explained to be including lack of taste, gag reflux, looseness, soreness, and possible breakage that may or may not be repaired. I realize the final opportunity to make changes in my new denture/partial (including fit, size, shape, color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately 3-12 months after initial placement. The cost relines is not included in the initial denture fee. I understand that immediate dentures serve as a temporary set primarily to satisfy patient aesthetics (so that the patient does not have to experience a time period without teeth). I further understand that all immediate dentures will best case need to be relined within the first 3 months or possible re-fabrication of a new set and the full charge will have to be applied.
8. **IMPLANTS:** I understand that no guarantees or assurances can be made on the outcome of implant placement surgery results. I also understand that the risk factors of uncontrolled diabetes, periodontal disease, bruxism (teeth grinding), lack of routine hygiene visits, and smoking will limit both the healing and the success of the implant and cause an increased risk in implant failure. I have been informed that the possible risks involved with implant placement surgery include prolonged bleeding, bruising, inflammation, infection at the implant site, injury or damage to surrounding structures (such as other teeth or blood vessels), nerve damage causing numbness or tingling (paresthesia lasting an indefinite period of time), limited jaw opening (trismus), and sinus perforation when implant protrudes into the sinus cavity. I understand that during or following implant placement surgery conditions may become apparent that warrant additional treatment such as bone grafting or even specialist referral for more specific procedures such as sinus lift prior to implant placement.
9. **BOTOX AND DERMAL FILLERS:** Botox is injected into targeted muscles that temporarily blocks nerve signals from causing muscle movements, essentially relaxing the muscle and allowing the overlying skin to lay flat and unwrinkled. I understand that Botox results are not usually seen until 3-5 days after initial injection and will last for 3-6 months. Dermal fillers made from naturally occurring hyaluronic acid are injected into collagen depleted aged skin to restore volume for a more natural, youthful appearance. I have been informed that results are more immediate and can last up to 6 months. I understand that Botox and dermal filler injections are cosmetic procedures that are not medically necessary and is not covered by insurances. I have been informed that Botox and dermal filler injections side effects include possible pain at the site of injection, infection, lumpiness, asymmetry, facial paralysis that can last for an indefinite period of time, skin cell death causing scarring, inflammation, redness, bleeding or bruising. Some of these symptoms may indicate allergic reaction. Other allergy symptoms are itching, wheezing, asthma, rash, red welts, dizziness, and faintness
10. **TEETH WHITENING:** I understand that since teeth whitening is a cosmetic procedure that it is not medically necessary and is not covered by most dental insurances. I have been informed that maintenance of teeth whitening results requires me to abstain from staining foods and beverages, some of which include red wine, tea, coffee, etc. I have also been informed that temperature sensitivity is a common side effect usually lasting 24-48 hrs after teeth whitening. It is not recommended for children or patients that have not lost all of their baby teeth to undergo teeth whitening. The only people who are not good candidates for whitening treatments are those who have had extensive dental work such as anterior fillings/bondings, crowns, bridges, or implants. These matters (resin or porcelain materials) do not bleach, so the teeth will whiten, but the fillings/bondings and crowns will not, leaving them two different shades. Teeth whitening should be completed prior to completing any extensive dental work so that the restorative work can be matched to the newly bleached teeth.

I hereby grant authority to the dentist to administer any treatment, anesthetics, nitrous oxide and/or drugs, and to perform such procedures deemed necessary or advisable in diagnosis or treatment. I have been informed of the possible complications of the procedures, anesthetics and/or drug administration.

Printed Name: _____

Signature: _____

Date: _____

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FINANCIAL POLICIES

Our mission is to deliver quality, comprehensive dental care. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. Please read the explanation of our company financial policies and initial and sign below:

INSURANCE BENEFITS:
It is imperative that you know and understand your insurance benefits prior to your appointment. If you are unsure of your benefits, please call the customer service phone number on your insurance card and have an insurance company representative explain your benefits regarding co-pays, deductibles, referral requirements, authorization requirements, etc.

I understand that even though the office will assist, it is my responsibility to know my insurance coverage.

_____ Initial

CO-PAYMENTS (IF APPLICABLE):
Co-pays will be collected when you arrive for your appointment. Please understand that you will have a co-pay for every office visit.

_____ Initial

FEES AND BALANCES:
I understand that Marino Family Dental requires fees and balances to be paid in full prior to the completion of your treatment. Any lab work (crowns, bridges, partials, dentures, etc.) will not be delivered until fees and balances are paid in full.

If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement of your treatment. However, if we do not receive payment from your insurance carrier, you are responsible for payment of your treatment fees and collection of your benefits directly from your insurance.

_____ Initial

INSURANCE CANCELLATION/TERMINATION/INELIGIBILITY:
In the event of cancellation or termination of your insurance plan, all previously quoted treatment plans through your insurance fee schedule of benefits will be lost and you will then be responsible for payment of the dentist's regular fee for all services yet to be performed or for any services already rendered determined to not be covered by your insurance plan due to termination/ineligibility of coverage.

_____ Initial

REFUNDS (IF APPLICABLE):

Refunds are determined only upon review of the case. Refunds, when applicable, on procedures that require laboratory work, will be returned less laboratory fees our office incurred. Refunds, when applicable, will be issued in no less than thirty (30) days from the date of receipt. If payment was by credit card, any refund will be on the same credit card minus a 3.5% handling fee

_____ Initial

CANCELLATION/NO SHOW POLICY:

Please be advised that Marino Family Dental requires 24-hour notice to cancel or reschedule your appointment. If you fail to cancel/reschedule your appointment within 24-hours of the appointment time, you will be billed a $25 fee.

_____ Initial

MEDICAL RECORDS REQUEST:

You have the right to request copies of your medical records. Medical records requests must be made in writing. It will take approximately 7-10 business days to complete, so your patience is much appreciated. Please be advised that original records are not released to patients, as dentists are required to maintain original records. There is a duplication charge for our time to locate and print paper copies of your medical records. An additional postage charge will be included if you choose to have your records mailed to you.

_____ Initial

TREATMENT PLANS/PAYMENT PLANS:

Marino Family Dental prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to us when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change. Your Treatment Plan Estimate of insurance benefits is based on information provided by your insurance company and by you. It is an estimate and your insurance benefits may be higher or lower than estimated. In all cases, you are responsible for amounts not covered by your insurance. we encourage all patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns relating to specific benefits.

Payment plan options are available for multi-visit appointment procedures to make treatment financially more feasible for our patients. Single visit procedure fees cannot be placed on a payment plan option and full payment is required prior to the completion of the appointment.

During treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I have read and understand the above stated company treatment plan and payment plan policies.

_____ Initial

BY SIGNING I CONFIRM THAT I HAVE READ AND UNDERSTAND THE COMPANY FINANCIAL POLICIES.

Printed Name: _____ Signature: _____

Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I acknowledge that I was provided a copy of The Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so choose) and understood the notice.

Patient Printed Name: _____

Patient Authorized Representative (if applicable):
or
Patient Signature: _____ Date: _____

COMPANY POLICIES

MEDICAL EMERGENCIES: Our office takes care of dental emergencies on a regular basis throughout the day. We also on occasion may have to deal with medical emergencies in the dental chair that require our immediate attention and additional time. Unfortunately, this may put us behind in our schedule. We will always try our best to be respectful of our patients' time and to see patients in a timely fashion for their scheduled appointment. However, please understand that if we are running extraordinarily late, our staff will offer our sincerest apologizes and will either keep you notified regarding the time you will be seen or kindly offer to reschedule the appointment.

_____ Initial

TARDINESS POLICY: Our staff will do their best in accommodating patients despite being late for their scheduled appointment time. However, if the patient is more than 25 minutes late, this can affect schedule flow and cause disruption to our other patients' scheduled appointment times. It is our office policy to kindly offer to reschedule this appointment when we are unable to accommodate tardy patients without jeopardizing our other appointments.

_____ Initial

CELL PHONE POLICY: Our office policy asks patients to refrain from cell phone use when seeing the doctor so as not to disrupt care. Your cooperation and understanding in this matter is very much appreciated.

_____ Initial

NO FOOD POLICY: It is important to us to maintain a sanitary and clean environment for our patients. It is our office policy to refrain from bringing food into our treatment rooms. Your cooperation and understanding in this matter is also very much appreciated.

_____ Initial

X-RAY POLICY: X-rays help your dentist see diseases of the teeth and surrounding tissue that cannot be seen with a basic visual oral examination and find and treat dental problems early in their development. This can potentially save you money, unnecessary discomfort and maybe even your life. To see is to know, not to see is to guess. Marino Family Dental does not guess about your dental health. I have read and understand the company X-Ray policy.

_____ Initial

BY SIGNING I CONFIRM THAT I HAVE READ AND UNDERSTAND THE COMPANY POLICIES.

Printed Name: _____ Signature: _____

Date: _____

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Dear Patient,

There are several dental procedures that you may have heard referred to as "dental cleanings." Some of there procedures are done to prevent periodontal (gum) disease from occurring (preventative treatment) while others are done to either stop or reverse the effects of the periodontal disease process (therapeutic). Please remember that those procedures that are therapeutic have an additional surcharge according to your Insurance Benefits.

ADA CODE 01110/01120 PROPHYLAXIS-ADULT/CHILD (PREVENTATIVE)

This is a routine cleaning of the permanent teeth of a patient whose gums are in normal condition with no periodontal disease present. A prophylaxis is a preventative treatment and is intended only for patients with no history of periodontal treatment (deep cleanings) or signs of periodontal disease. It includes the removal of plaque and calculus (tartar) from the crown of the tooth above and/or sometimes slightly below the gum line. The teeth are also polished. Only this dental cleaning is covered at no additional cost. If you have gingivitis but no periodontal pocket measurements, your dentist may determine that you need to have this procedure performed more frequently than every 6 months. In this case, there is a specific copayment according to your Insurance Benefits.

ADA CODE 4355 FULL MOUTH DEBRIDMENT "GENERALIZED CLEANING" TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION & DIAGNOSIS

This cleaning is for the removal of plaque and calculus that obstructs the ability to perform an oral evaluation. Extensive deposits of calculus (tartar) will prevent your dentist from obtaining accurate readings for periodontal diagnosis. The next step after this procedure is an oral examination and periodontal charting to determine the presence or absence of periodontal (gum) disease. This is a therapeutic treatment, not preventative care, and it may have an additional surcharge according to your Insurance Benefits.

ADA CODE 045341 PERIODONTAL SCALING & ROOT PLANING "DEEP CLEANING" (THERAPEUTIC)

This procedure removes plaque and calculus (tartar) from both the crown and the root of the tooth. Scaling and root planing is very time consuming and requires local anesthetic. This is a therapeutic treatment usually associated with moderate to severe periodontal disease, (presence of periodontal pocket measurements), and has an additional surcharge according to your Insurance Benefits.

ADA CODE 4910 PERIODONTAL MAINTENANCE

This procedure is for patients who have completed periodontal treatment. Includes removal of bacterial from pocket areas, scaling and polishing teeth, and a review of the patient's plaque control efficiency. This becomes the necessary cleaning for any patient who has a history of periodontal disease. Patients with this type of dental history have improved to a point where they may be placed in a maintenance program. Once a patient has had a history of periodontal disease, the patient cannot return to a "regular" cleaning but rather are required to stay on periodontal maintenance cleanings. This procedure may have an additional surcharge according to your Insurance Benefits.

Treatment plans are developed according to each individual's DIAGNOSED oral conditions. The dentist and hygienist will recommend treatment based on such DIAGNOSED conditions. Please do not ask you doctor to provide only the "NO CHARGE" benefits and neglect treatment that is in the best interest of your own oral health as this is considered fraud.

Printed Name: _____ Signature: _____

Date: _____