

MIRACLE SMILE



PATIENT REGISTRATION FORM

Thank you for choosing Miracle Smile Dentistry, we deeply care about all of our patients. We strive to offer the highest standards of oral care in the most professional and sensitive manner. If you have any concerns or questions, please let us know.

First Name: State / Zip: Country:	Reason for your visit:	How did you hear	about us?
Address: City: State / Zip: Country: Telephone #1: Besponsible Party (if other than the patient) Responsible Party (if other than the patient) Responsible Party (if other than the patient) Responsible Party is also the Primary Policy Holder First Name: Last Name: Middle Initial: Telephone #2: Email: Responsible Party (if other than the patient) Responsible Party is also the Primary Policy Holder First Name: Middle Initial: Telephone 1: State / Zip: Country: Telephone 1: State / Zip: Country: Telephone 2: Interphone 1: Besponsible Party (if other than the patient) Sex: Male Female Marrial Status: Married Single Divorced Separated Widowed Date of Birth: Social Security: Email: Insurance Information (if any or if not already given to our office) Self Spouse Child Other Name of Primary Holder: DOB: SS# Insurance Company Name & Phone #: Employer Name & Phone #: Do you like your teeth? Yes No If no, why? Patient Questionnaire Do you gums bleed? Patient Questionnaire Do you gums bleed? Patient Questionnaire Are you interested in Teeth Whitening? Yes No Please ask the front desk about our special promotion for new patients) Are you interested in Teeth Whitening? Yes No Please ask the front desk about our special promotion for new patients) Would you like to hear about our Invisalign Promotion this month? Yes No In what language do you prefer to speak?			
Telephone #1:			
Sex:	City:	State / Zip: (Country:
Date of Birth: Social Security: Enail:	Telephone #1:	🗆 Home 🗆 Work 🗆 Mobile — Telephone #2:	□ Home □ Work □ Mobile
Date of Birth: Social Security: Enail:	Sex: □ Male □ Female	Marital Status: ☐ Married ☐ Single	□ Divorced □ Separated □Widowed
Erist Name: Last Name: Middle Initial:			•
Address: City: State / Zip: Country:	Responsible Party (if other than the	patient) □ Responsible Party is also the Prir	mary Policy Holder
City: State / Zip: Country:	First Name:	Last Name:	Middle Initial:
City: State / Zip: Country:	Address:		
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed Date of Birth: Social Security: Email: Insurance Information (if any or if not already given to our office) Self Spouse Child Other Name of Primary Holder: DOB: SS# Insurance Company Name & Phone #: ID#: Employer Name & Phone #: Group#: Patient Questionnaire Do you like your teeth? Yes No If no, why? Do your gums bleed? Yes No Have you previously received a cleaning? Yes No When? When was the last time you went to the dentist? Are you interested in Teeth Whitening? Yes No Please ask the front desk about our special promotion for new patients) Are you afraid of going to the dentist? Yes No Please ask the front desk about our special promotion for new patients) Would you like to hear about our Invisalign Promotion this month? Yes No In what language do you prefer to speak?			
Date of Birth: Social Security: Email:	Telephone 1:	□ Home □ Work □ Mobile Telephone 2:	□ Home □ Work □ Mobile
Insurance Information (if any or if not already given to our office)	Sex: □ Male □ Female	Marital Status: ☐ Married ☐ Single	□ Divorced □ Separated □Widowed
Name of Primary Holder: DOB: SS#	Date of Birth: So	cial Security: En	nail:
Insurance Company Name & Phone #: ID#: Employer Name & Phone #: Group#: Patient Questionnaire Do you like your teeth? Yes No If no, why? Do your gums bleed? Yes No Have you previously received a cleaning? Yes No When? When was the last time you went to the dentist? Are you interested in Teeth Whitening? Yes No (Please ask the front desk about our special promotion for new patients) Are you afraid of going to the dentist? Yes No Terrified Are you interested in "laughing gas" better known Nitous oxide Yes _ No_ Are you interested in Botox? Yes No (Please ask the front desk about our special promotion for new patients) Would you like to hear about our Invisalign Promotion this month? Yes No In what language do you prefer to speak?	Insurance Information (if any or if	not already given to our office) □ Self	□ Spouse □ Child □ Other
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In what language do you prefer to speak?	Are you interested in Botox? □ Yes □ I	No (Please ask the front desk about our special p	promotion for new patients)
	Would you like to hear about our Invisalig	n Promotion this month? Yes No	
Signature: Date:	In what language do you prefer to speak?		
Total Control of the	Signature:		Date:



SIGNATURE OF PATIENT, PARENT, or GUARDIAN

MIRACLE SMILE

MEDICAL HISTORY

Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Are you taking any medications, pills, or drugs? Yes No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeins Local Anesthetics Acrylic Metal Latex Sulfa Cither If yes, please explain: Or you have, or have you had, any of the following? Dishelve Yes No Disbetes Yes No Disbetes Yes No Disbetes Yes No Disbetes Yes No Hemophilia Yes No Hempatilis A Hempatilis B or C Yos No Hepatilis B or C Yos No Hepatilis B or C Yes No Hepatilis	PATIEN	IT NAME						Birth Dat	e				*
we you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Yes No Have you taking any medications, pills, or drugs? Yes No Have you taken, Phen-Fen or Redux? Have you atken, Phen-Fen or Redux? Yes No Have you atken, Phen-Fen or Redux? Are you on a special diet? Ob you use controlled substances? Are you on a special diet? Ob you use controlled substances? Yes No Do you use controlled substances? Yes No No Momen: Are you Do you use controlled substances? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfat Other If yes, please explain: Do you have, or have you had, any of the following? DSHIV Positive Yes No Do you have, or have you had, any of the following? DSHIV Positive Yes No Do you have, or have you had, any of the following? DSHIV Positive Yes No Do you Addiction Yes No Demand Disease Yes No Do you Addiction Yes No Hepatitis G or Hepatitis G o	nave, or medication	i triat you	imarily may b	treat the area in and a e taking, could have a	around you n importar	ur mou nt inter	th, your r relationsh	nouth is a part nip with the der	of your ntistry y	entire l	body. Health problems the receive. Thank you for ar	at you m	ay the
Have you ever been nospitalized or had a major operation? Yes No If yes, please explain: Have you ever had a serious head or neck injury? Yes No If yes, please explain: Are you taking any medications, pills, or drugs? Yes No If yes, please explain: Do you take, or have you taken, Phen-Fen or Redux? Yes No Have you ever taken Fosamax, Boniva, Actionel or any other medications containing bisphosphonates? Yes No Dyou use tobacco? Yes No Dyou use tobacco? Yes No Dyou use controlled substances? Yes No Nomen: Are you Do you use controlled substances? Yes No Nomen: Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfation of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfation of the following? DO you have, or have you had, any of the following? DO you have, or have you ha	Ar	e you und	der a p	hysician's care now?	Yes	No	If wee ni	esce evolsin:					
Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Are you taking any medications, pills, or drugs? Yes No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeins Local Anesthetics Acrylic Metal Latex Sulfa Cither If yes, please explain: Or you have, or have you had, any of the following? Dishelve Yes No Disbetes Yes No Disbetes Yes No Disbetes Yes No Disbetes Yes No Hemophilia Yes No Hempatilis A Hempatilis B or C Yos No Hepatilis B or C Yos No Hepatilis B or C Yes No Hepatilis	ive you ever been h	ospitalize	d or ha	d a major operation?	Total Control	No	If yes, pi	ease explain:					
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: Do you take, prhave you taken, Phen-Fen or Redux? Yes No Have you sever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Norman: Are you pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Norman: Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfation of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfation of the following? Do you have, or have you had, any of the following? DSH-IV Poetitive Yes No Drug Addiction Yes No Hepatitis A Yes No Hepatitis B or C Ye	Have you eve	er had a s	erious	head or neck injury?		No	If yes, pi	case explain:		-			
Do you take, or have you taken, Phen-Fen or Redux? Yes No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphopshonates? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Nomen: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Nore you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfator of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfator of the following? District Files of the following	Are you tak	ting any m	nedica	lons, pills, or drugs?		1 440	11 J 001 M	CESE GANIEIII.					
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Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No No Nursing? Yes No Nursi	Have you ever tal	ken Fosan	nax. B	oniva. Actonel or any									
Do you use tobacco? Yes No Do you use controlled substances? Yes No Normen: Are you pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Cother If yes, please explain: Do you have, or have you had, any of the following? Districtly Positive Yes No Cortisone Medicing Yes No Hemophilia Yes No Diabeles Yes No Hepatitis A Yes No Hepatitis B or C Yes No Hepatitis B or C Yes No Hepatitis B or C Yes No Hematis Yes No Hematis Yes No Hematis Yes No Herpes Yes No Hematis Gout Yes No Easily Winded Yes No High Blood Pressure Yes No High					Van	Na							
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Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfat Cother If yes, please explain: Do you have, or have you had, any of the following? DSI-HIV Positive Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes Renal Dialysis Yes No Herpes Yes No Helpes Yes No Genital Herpes Yes No Genital Herpes Yes No Genital Herpes Yes No Heart Attack/Failure Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Heart Murmur Yes No Heart Murmur Yes No Parchitaric Care Yes No Heart Murmur Yes No Heart Murmur Yes No Parchitaric Care Yes No Heart Murmur Yes No Parchitaric Care Yes No Heart Murmur Yes No Parchitaric Care Yes No Helpes Yes No Heart Trouble/Disease Yes No Parchitaric Care Yes No Helpes Yes No Helpes Yes No Helpes Yes No Helpes Yes No Parchitaric Care Yes No	Nomen: Are you	Do you o	ase co	itrolled substances?	Yes	NO							
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DS/HIV Positive Yes No Diabetes Yes No Drug Addiction Yes No Hepatitis A Hepatitis B or C Yes No Hepatitis B or C Herpes Yes No Hilves or Rash Yes No Sickle Cell Disease Yes No Sickle Cell Disease Yes No Distance Yes No Frequent Cough Yes No Leukemia Yes No Leukemia Yes No Genital Herpes Yes No Genital Herpes Yes No Genital Herpes Yes No Genital Herpes Yes No Heart Attack/Failure Yes No Heart Murmur Yes No Heart Murmur Yes No Heart Trouble/Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No No Heart Trouble/Disease Yes No Parathyroid Disease Yes No No Heart Trouble/Disease Yes No Parathyroid Disease Yes No No Heart Trouble/Disease Yes No Parathyroid Disease Yes No Verellow Jaundice Yes Verellow Jaundice	Other If yes, pl	ease expl	ain: _							V			
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Have you ever had any serious illness not listed above? Yes No						ALCOHOLD TO	Parath	yroid Disease				Yes	No.
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the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be	the best of my kno	wiedge, t	he que	estions on this form ha	ve been a	ccurat	ely answe	ered. I underst	and tha	at provid	ding incorrect information	can be	
angerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	angerous to my (or	patient's)	nealth	. It is my responsibility	y to inform	the de	ental offic	e of any chang	es in m	redical	status.	ALL DESCRIPTION	



FINANCIAL POLICY & GENERAL CONSENT FOR DENTAL TREATMENT



(PLEASE READ CAREFULLY)

FINANCIAL POLICY

Financial arrangements must be made in advance. We accept cash, personal checks, cashier's check, money orders, Visa, MasterCard, Discover and American Express. We also offer alternative payment plans (based on approval) as an option for financial arrangements. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. All treatment plans presented are valid only for 3 months unless otherwise stated.

DELINQUENT ACCOUNTS

The undersigned acknowledges that all accounts are due and payable within 30 days of the invoice date. An interest charge of 1.5% per month will be applied to any unpaid balance. In the event this account is in default and your file is placed with a collection agency, a charge up to 50% of the amount owed will be added to your account and will be your responsibility to pay. You also agree to pay all court costs and attorney fees, whether suit is filed or not. In the event that suit is filed, venue will be Broward County, Florida. The undersigned gives Miracle Smile Dentistry and/or its agents permission to text or email information regarding this agreement.

Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

GENERAL CONSENT FOR DENTAL TREATMENT

I hereby authorize Miracle Smile Dentistry's staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my/my child's dental needs. Upon such diagnosis, I authorize this office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I grant my permission to telephone me at home, work or cell to discuss matters related to this form, appointments and treatment. I understand and acknowledge that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes and I agree to the same. I authorize dental benefits to be paid directly to Miracle Smile Dentistry.

I understand my dentist reserves the right where appropriate to provide me with a more specific consent for some dental treatments. I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to not receive treatment although that carries with it its own risks. I am aware that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that routine fillings, dental cleanings, and prescription of medications may cause temporary soreness, tooth sensitivity, and unusual reactions/allergies to medications given or prescribed. Further, if I am taking medications these could have an adverse interaction, and I need to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements. I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction, or temporary or permanent injury to the nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of a post-operative infection, nerve damage, and iatrogenic injury. In rare cases, the complications from surgery can be permanent, disabling, or even causing death. I understand the infection area(s) may be uncomfortable following treatment and that my jaw may be stiff and/or sore from holding my mouth open during treatment. I understand that all treatments and procedures have a risk of separation of dental instruments which my become lodge in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment I will contact the treating dentist at Miracle Smile Dentistry.

I understand that the practice of dentistry is not an exact science and my dentist cannot offer any guarantees or assurances as to the outcome or result of the treatment or surgery. I have the right to ask the treating dentist for more information if I have concerns about my procedures and the possible side effects or complications. I promise to use that right to its fullest intent if for any reason I feel I am not fully informed about my procedure, the risk of the procedure, and my alternatives.

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

M

APPOINTMENT CANCELATION POLICY



Please understand that a missed appointment incurs expenses to our office. We value your time and we expect that you value ours. We understand that sometimes circumstances come up that cause patients to miss appointments.

If for some reason you cannot come to your scheduled appointment, please let us know 48 hours in advance; otherwise a <u>\$100 missed appointment fee</u> will be charged to your account.

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

Patient/Guardian Signature

Relationship to Patient

Date

M NOTICE TO PATIENTS WITH INSURANCE



Please understand that our service for processing your claims is a courtesy and not our obligation. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Every plan design is different for every employer group. Your dental insurance is a benefit provided by your employer and the contract is between the patient, the employer and the insurance company, not the dentist.

Your insurance wants us to let you know that a predetermination of benefits is not a guarantee of coverage. We will do our best to process your claim successfully. Your copayment is due at the time of treatment and benefits will only be paid by the insurance once they receive and process the claim. Unpaid benefits, if any, will be the patient's responsibility. Claims taking more than 30 days to process will need to be paid by the patient or responsible party and we will refund as soon as we receive payment from your insurance.

The following is how we work with you regarding your insurance benefits.

- You, the patient, are responsible for the entire treatment fee regardless of insurance benefits. We ESTIMATE your portion and deductible to be paid at time of treatment.
- Our office accepts most PPO insurance plans. We will ESTIMATE co-payments, deductibles and patient portions at the time treatment plans are presented. We cannot guarantee estimated co-payments as payment in full.
- We reserve the right to bill for unforeseen circumstances such as Calendar Year Maximums, Non-Covered services, Non-Duplication Clause or Alternate Benefit Clauses. As the insured employee, you are responsible for knowing and understanding your own insurance contract. Please verify your insurance benefits with your insurance carrier.

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

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH IMFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

*CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with MIRACLE SMILE DENTISTRY/ ANNA ALLER D.M.D., "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

*Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de with MIRACLE SMILE DENTISTRY/ ANNA ALLER D.M.D., y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.

Patient Name: (please print)	
Nombre Del Paciente: (nombre en letra de molde por favor	
Patient Signature (or legal representative; proof may be requested)	
Firma Del Paciente: (o representante legal; prueba puede ser requerida)	
Date: (dd/mm/yy)Fecha: (dd/mm/yy)	
ectia. (aa/mm/aa)	
FMAIL /TEVT MESSA OF TO MODILE BUICNES CONSENT FORM	
EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM	
*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A	MOVIL
Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected H SMILE DENTISTRY/ ANNA ALLER D.M.D., (MSD/AADMD) offers patients the opportunity to communicate by email/mobile text mess information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email these purposes. MSD/AADMD will use reasonable means to protect the security and confidentiality of email/mobile text messaging inf However, MSD/AADMD cannot guarantee the security and confidentiality of email/mobile text messaging communication and will n	saging. Transmitting patient l/mobile text messaging for ormation sent and received.
disclosure of confidential information.	
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mol MSD/AADMD and me and consent to the conditions outlined herein. Any questions I may have had were answered.	bile text messaging between
*Propósito: Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en de Salud Protegida. MIRACLE SMILE DENTISTRY/ ANNA ALLER D.M.D, (MSDAADMD) ofrece a sus pacientes la oportunidad de electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que antes de otorgarnos este consentimiento para estos propósitos. MSDAADMD usara formas razonables de proteger confidencial y segur usted vía correo electrónico/mensaje de texto a móvil. De todas formas, MSDAADMD no podrá garantizarle proteger confidencial y correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvert. Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con electrónico/mensaje de texto a móvil entre MSD/AADMD y yo y consiento a las condiciones que me han sido dadas. Cualquier pregur sido respondida.	e comunicación vía correo el paciente debe considerar o la información mandada a seguro la comunicación vía damente por otros. la comunicación vía correo
Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente	
No. Conserved Front Address to	
My Consented Email Address is:*Mi Correo Electrónico Consentido es:	
THE COLLEGE STATE OF THE COLLE	
My Consented for Text Messaging to:	
*Mi Mensaje de Textos consentido a:	
X * Firma del Paciente	
THE MALE MANAGEMENT OF THE PROPERTY OF THE PRO	
Date *Fecha	

Cancellation Policy

We value your time, and we expect that you value ours. We understand that sometimes circumstances come up that cause patients to miss appointments.

If a need arises to cancel or reschedule your appointment, please let us know 48 hours in advance; otherwise a \$100 missed appointment fee will be charged to a credit card that will be on file.

Please note that failure to comply with our cancellation policy or miss more

than three appointments may result in a dismissal from our office.
Please complete the information below:
I understand that Miracle Smile Dentistry will charge my credit card \$100 if I do not make it to my appointment/cancel less than 48 hours prior to my appointment. I understand that I may lose my privileges to have further appointments if I fail to comply with the cancellation policy in effect or miss more than three appointments.
Credit Card Authorization Form:
Card type: VISA MasterCard Mex Discover
Cardholder name
Credit Card #
Expiration date
Security code
Billing address
City, state, zip
I have read the above conditions and agree to their content.
Patient/Guardian Signature
Relationship to Patient
Date

CONSENT FORM FOR COVID-19

Your health and well-being is our top priority. In response to the Coronavirus Pandemic, we are closely following and adhering to precautions advised by the Center for Disease Control (CDC), Florida Department of Public Health and the American Dental Association (ADA).

All patients will be screened for risks of COVID-19 before their appointments. Individuals with symptoms of respiratory infection (fever, cough, shortness of breath, flu-like symptoms), and individuals who have come into contact with a person with known COVID-19 within the past 14 days, or who have traveled in areas where there is wide community spread of COVID-19, should not be seen at the office at this time.

You are receiving dental care during the events of a COVID- 19 pandemic. Please be advised that there may be risks in being in proximity of dentists, patients or staff. We are taking precautions to limit the spread of disease, yet there is a still possibility of transmission.

Upon starting your appointment we kindly ask that you follow these guidelines:

- We request only patients with scheduled appointments enter the office wearing facemasks.
- Please use good hand hygiene, either washing your hands with soap and water for 20 seconds or by using hand sanitizer.
- Avoid touching your eyes, nose and mouth with unwashed hands.
- Cover your coughs and sneezes by coughing/sneezing into your elbow. Clean your hands after coughing or sneezing.

We want to assure you that we are taking continuous steps to ensure that our office remains a safe place for every patient. It's important for you to know that dentists are experts in infection control. For instance, we have been trained to prevent the spread infectious diseases such as the flu, HIV, hepatitis, and tuberculosis. The precautions we take every day will also help prevent the spread of coronavirus.

Patient's (or Legal Guardian's) Signature	
Patient's (or Legal Guardian's) Name:	
Today's Date:	