Welcome

Thank you for choosing Green Bench Dental. We will strive to provide you with the best possible dental care. To help us meet all your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help!

Patient Information (CONFIDENTIAL) **Today's Date.....**

Name.....Birth date...../...../.....Social Sec#.....-.....-.....

Address.....

City.....State.....Zip.....

Home Phone: .....Cell Phone:.....Email Address:.....
Do you opt in for email/text reminders? ( ) YES ( ) NO

Check Appropriate Box: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Retired

If Student, Name of School/College.....City.....( ) Full time ( ) Part time
Patient's or Parent's Employer.....Business address.....

Spouse or Parent's Name..... Employer.....

Person to Contact in Case of Emergency.....Phone #.....

Whom May We Thank for Referring You? .....

Responsible Party

Name of Person Responsible for this Account.....Relationship to Patient.....
Address..... Phone #.....
Driver's License Number.....Birth date.....Social Sec#.....

Minor Patients

For patients who are not personally financially responsible for their account, arrangements for payment must be made prior to appointments.

Payment Options

Our office policy <u>requires</u> payment for service at the time of treatment. For your convenience, we offer the following methods of payment. We will be happy to discuss our office's payment options with you. Please check the option you prefer.

( ) Cash ( ) Personal Check ( ) Visa ( ) MasterCard ( )ATM/debit

Insurance Information

Since dental insurance affords improved dental care for our patients, it is our goal to work to expedite your dental insurance claims. Please inform us if you have dental insurance, so we may assist you in filing your claims. Your insurance policy is a contract between you and your insurance company. As your dental health provider, we are not a party to your personal insurance contract. In the event we do accept assignment of benefits we require that you be pre-approved by your insurance company and sign the assignment request: *When applicable, I authorize and request my insurance company to pay Green Bench Dental any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I am responsible for the balance at time of service.*

X.....(Signature of Patient) *Dated:*.....

Name of Insured (if other than Patient).....Relationship to Patient.....

Birth date.....Social Security.....Date Employed.....

Name of Employer.....Address of Employer.....

Insurance Company..... Insurance Co. Address.....

Group #.....Policy-ID #.....Insurance Co. Phone Number:.....

Do You Have any additional Dental Insurance? .....( ) NO ( )YES.....

Green Bench Dental, LLC
Lauren Krauser D.M.D.
1015 58th Street North, Saint Petersburg, FL 33710 (727) 381-2809 email: frontdesk@greenbenchdental.com

PATIENT MEDICAL HISTORY UPDATE

Your Name……Date…….....

Your Physician is:.....Office Phone.....Date of Last Exam.....

Are you under medical treatment for chronic or acute conditions? ( )Yes ( )No If yes, please explain.....
.....

Have you ever been hospitalized within the last year? ( )Yes ( )No If yes, please explain.....
.....

Have you ever been to a cardiologist?( )Yes ( )No Have you had cancer radiation treatment near your jaws?.. ( )Yes ( )No
Do you use tobacco?.....( )Yes ( )No Do you vape?.....( )Yes ( )No
Do you use marijuana? .....( )Yes ( )No Do you use dip, chew or snuff or snort.....( )Yes ( )No
Have you taken bisphosphonates, like Fosamax, Actonel, Boniva? ( )Yes ( )No...If yes, when?.....

Please list all ALLERGIES: Allergic reactions may include hives, swelling and difficulty breathing. Allergies may include antibiotics such as penicillin, other medicines, aspirin, metals, latex:.....
.....
Please list all sensitivities or adverse reactions to medications: Reactions usually involve nausea, vomiting or malaise, and pain medications are the most common:.....
.....
For **WOMEN** Only: Are you pregnant or think you may be pregnant? ( )Yes( )No Are you nursing? ( )Yes ( )No
Are you taking oral contraceptives? ....( )Yes ( )No If yes, Type:.....

Please list all current and past medical conditions. Please check appropriate answer boxes.

High Blood Pressure.... ( )Yes ( )No	Heart Disease..... ( )Yes ( )No	Chest Pains..... ( )Yes ( )No
Heart Attack..... ( )Yes ( )No	Cardiac Pacemaker..... ( )Yes ( )No	Easily Winded..... ( )Yes ( )No
Rheumatic Fever..... ( )Yes ( )No	Heart Murmur.....( )Yes ( )No	Stroke..... ( )Yes ( )No
Swollen Ankles..... ( )Yes ( )No	Angina.....…( )Yes ( )No	Hay Fever/Allergies.. ( )Yes ( )No
Fainting/Seizures..... ( )Yes ( )No	Frequently Tired..... ( )Yes ( )No	Tuberculosis..... ( )Yes ( )No
Asthma..... ( )Yes ( )No	Anemia.....( )Yes ( )No	Radiation Therapy... ( )Yes ( )No
Low Blood Pressure.... ( )Yes ( )No	Emphysema.....( )Yes ( )No	Glaucoma..... ( )Yes ( )No
Epilepsy/Convulsions.. ( )Yes ( )No	Cancer.....( )Yes ( )No	Recent Weight Loss ( )Yes ( )No
Leukemia.....…. ( )Yes ( )No	Arthritis..... ( )Yes ( )No	Liver Disease..... ( )Yes ( )No
Diabetes.....( )Yes ( )No	Joint Replacement/Implant . ( )Yes ( )No	Heart Trouble.....…( )Yes ( )No
Kidney Diseases..... ( )Yes ( )No	Hepatitis/Jaundice.....( )Yes ( )No	Respiratory Problem ( )Yes ( )No
AIDS or HIV Infection... ( )Yes ( )No	Sexually Transmitted Disease( )Yes ( )No	Thyroid Problem..... ( )Yes ( )No
Stomach disease/Ulcers( )Yes ( )No	Blood disease....….....( )Yes ( )No	Chemotherapy.....( )Yes ( )No
Artificial Heart Valve..... ( )Yes ( )No	Anticoagulant Use..... ( )Yes ( )No	Osteoporosis.....( )Yes ( )No

Please list Rx medications and dosage	**Prescribed for? (medical condition)**	**Doctor's name on Rx**
Example: Lisinopril 10mg/day	High blood pressure.....	Dr. John Doe.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Or, please attach a copy of a similar list! (We will be glad to copy for you)
Please list all over the counter medicines, including vitamins, herbal supplements, analgesics:.....
.....

Doctor's notes.....

PATIENT DENTAL HISTORY

Please check appropriate answer box.

Name of Previous Dentist and Location.....Date of Last Exam.....

1. **Please state briefly the reason for your visit**:.....
2. Do you like your smile?..... ( )Yes ( )No
3. Are your teeth sensitive to hot or cold liquids/foods?..... .( )Yes ( )No
4. Do you have any sores or lumps in or near your mouth?..... ( )Yes ( )No
5. Did you ever have gum treatments?..... ( )Yes ( )No
6. Do your gums bleed while brushing or flossing?..... ( )Yes ( )No
7. Have you had any orthodontic treatment or braces?..... .( )Yes ( )No
8. Are you satisfied with your past dental care?..... ( )Yes ( )No
9. Have you ever had any gum surgery?..... ( )Yes ( )No
10. Do you bite your lips or cheeks frequently?..... ( )Yes ( )No
11. Are you troubled with dryness in your mouth?..... ( )Yes ( )No
12. Have you ever had any prolonged bleeding following extractions?..... .( )Yes ( )No
13. Do you wear removable dentures or partials or plates?.....( )Yes ( )No If yes, date of placement.....
    If yes, are you satisfied with them presently?..... ( )Yes ( )No
14. **What type of toothbrush do you use? Hard ( ) Medium ( ) Soft ( ) Frequency/day: 1x 2x 3x more**
15. Do you floss your teeth daily?.....( )Yes ( )No
16. Have you had any head, neck or jaw injuries?.....( )Yes ( )No
17. Have you ever experienced any of the following problems in your jaw?
    A. Clicking..... ( )Yes ( )No C. Difficulty in opening or closing.....( )Yes ( )No
    B. Pain (joint, ear, side of face).....( )Yes ( )No D. Difficulty in chewing.....( )Yes ( )No
18. Have you ever had bite work, a bite guard or TMJ therapy?.....( )Yes ( )No
19. Do you clench or grind your teeth?..... ( )Yes ( )No
20. Do you have frequent headaches?..... ( )Yes ( )No
21. Do you feel pain in any of your teeth?..... ( )Yes ( )No
22. Have you ever had a root canal..... ( )Yes ( )No
23. Concerning our dental care for you. What do you prefer?

A. ____to learn every detail of my care	_____ just an overall explanation.
B. ____the latest, technically - advanced techniques	_____ tried and tested methods.
C. ____long-lasting solutions	_____ temporary low-cost solutions.
D. ____to let my insurance coverage control my care	_____ let my doctor control my care.

Missed Appointments

We reserve time specifically for your dental care, which is unavailable to other patients for their needs. Broken, unfilled or unused appointments affect all patients, and we require 48 hours advance notice on all appointment changes. We may levy a surcharge on broken, unfilled appointments to keep fees low for others. We will strive to be on time for your appointment barring unforeseen emergencies.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that this information will be held in the strictest of confidence, and it is my responsibility to inform Dr. Pittman's staff of any changes in my medical status. I authorize the dental staff to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to my child or me during the period of such dental care to third party payer and/or health practitioner. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X.....Date.....

Signature of patient (or parent if minor)

I reviewed verbally the medical/dental information above with the patient named herein.

Initials.....Date.....

Doctor's

Comment's:.....

.....

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.....

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PATIENT'S NAME _____

Green Bench Dental, LLC

Late Cancellation And Missed Appointment Policy

Because of the increasing number of patients that either no-show for their scheduled appointment or give less than 48 hours' notice for cancellation, we have been forced to initiate a new late cancellation/missed appointment policy. This policy applies to all patients, new and established.

In order to be respectful of the dental needs of our patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who needs to be seen for an urgent dental problem or someone who is on our waitlist for an appointment. This is how we can best serve the needs of all our patients.

We will call you one week and 24 hours in advance to remind you of your scheduled appointment. (Please make sure we have your updated contact information.) If it is necessary to cancel/reschedule your appointment, we ask that you call us at least 48 hours in advance at (727)381-2809. In the event a 48-hour notice of cancellation is not given, a fee of $50.00 may be assessed for an office appointment. These fees are not covered by your insurance and are your personal responsibility.

If two (2) or more appointments are missed consecutively, we respectfully reserve the right to terminate our relationship with the patient.

If a patient does not comply with this policy or refuses to pay a late cancellation/missed appointment fee, the patient hereby gives Green Bench Dental, LLC, the permission to seek payment for said fees.

I have read the late cancellation/missed appointment policy for Green Bench Dental, LLC, and understand the above.

_____
Patient Name

_____ _____
Patient Signature Date

INSURANCE SUBMISSION POLICY

Our office will submit dental insurance claims for you. Please understand the following common insurance practices:

1) Insurance benefits paid may not cover the office fee charged for some servicesrendered.

REASON: Insurance benefit fee scales (described as: "usual,"customary," and "reasonable," etc.) are determined solely by your insurance company and do not reflect actual fees. The delivery of high quality services is not always possible at the "allowable benefit" paid by your insurance.

2) Insurance benefits for certain services may be denied or paid at a reduced level.

REASON: To limit claims liability (thus maximizing profits), insurance companies have treatment exemptions and exclusions based upon their own restrictive criterion or definition of "necessity."

Insurance companies and their paid consultants function as dispensers of limited payable benefits and are motivated to withhold or deny coverage. In contrast, our goal is to provide high quality service and promote optimal dental health and function for long term success.

Our office policy requires payment for service at the time of treatment. We occasionally make an exception to accept assignment of benefits. We require pre-approval by your insurance company and your signature on the assignment request. As contractually agreed between you and the insurance company, the patient copayment and deductible are due at the time of service. If we accept assignment, payment from insurance company must be received within 30 days. If your insurance company delays payment beyond one month, we require that you pay the balance due. If insurance proceeds are later received, they will be assigned directly to you.

I have reviewed the above information and agree to its terms.

_____ _____

Patient/Patient Guardian Date

Green Bench Dental, L.L.C.
1015 58th Street North, Saint Petersburg, FL 33710
(727) 381-2809

Privacy Notice

This notice describes how Medical Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Your protected health information (individually identified information, such as names, dates, phone numbers, email addresses, home address, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following aspects. This Privacy Notice is effective as of the date of your signature. Thank you.

1. To other health care providers (specialist such as oral surgeons, endodontists, etc.) in connection with our rendering treatment to you.
2. To third party payors and spouses (insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (to determine benefits, dates of payment, etc)
3. To certifying, licensing, and accrediting bodies (state dental boards) in connection with obtaining certification, licensure, or accreditation.
4. Internally, to all staff members who have a role in your treatment
5. To other patients and third parties who may see or overhear incidental disclosures about your treatment scheduling, etc.
6. To your family or close friends involved in your treatment.
7. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you and/or follow up calls from the doctor or staff to check on your post operative comfort.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the privacy rules, you have the right to:

1. Request restrictions on the use and disclosure of your protected health information.
2. Request confidential communication of your protected health information.
3. Inspect and obtain copies of your protected health information through making a request to us.
4. Amend of modify your protected health information in certain circumstances.
5. Receive or modify your protected health information in certain circumstances.
6. You may, without risk of retaliation, file a complaint as to any violation by us to your privacy rights with us (by submitting inquiries to our Privacy Contact person, Peter Krauser, at 1015 58th St North, St. Petersburg, FL 33710 (727) 381-2809 or the US Secretary of Heath and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the Privacy Rules:

1. By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information.
2. To abide by the terms of our Privacy Notice that is currently in effect.
3. To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note we are not obligated to:

1. Honor any requests by you to restrict the uses or disclosure of your protected information.
2. Amend your protected health information if, for example, it is accurate and complete.
3. Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

Revised May 2020

Acknowledgement / Consent of Receipt of Notice of Privacy Practices

You may refuse to sign this document

I acknowledge that I have received a copy of Green Bench Dental, LLC's Notice of Privacy Practices and consent to the new policies with the effective date May 1, 2019. A copy of this signed and dated Acknowledgement and Consent form shall be as effective as the original.

_____ _____

Print Name Date

_____ _____

Signature of Patient/Patient Representative Relationship to Patient

Thank you and if you have any questions please contact our privacy office, Peter Krauser at (727) 381-2809.