Cori S. Hvideberg DMD, PA
General Dentistry

Patient Information

Patients Name _____ **Date of Birth** _____

Street Address _____

City/State/Zip Code _____

Are you a full-time resident? Y / N

If NO please list northern address: _____

Social Security Number _____

Preferred method of contact? Home / Cell / Text / E-mail

Home phone: _____ **Cell Phone:** _____

E-Mail Address: _____

Marital Status _____ **Emergency Contact/Phone:** _____

Patients Occupation _____**Employer** _____

Do you have dental insurance? Y /N

Insurance Company: _____ **Phone:** _____

Subscriber Name: _____ **Date of birth:** _____

Subscriber ID: _____

Whom May We Thank for This Referral? _____

- **I consent to treatment for the care of the above-named patient.**
- **I authorize the release of all dental related records to the referring dentist.**
- **I allow fax and or email transmittal of my dental records, if necessary.**
- **I acknowledge full financial responsibility for services rendered by Dr. Cori s. Hvideberg and authorize the transfer of all unpaid amounts to my Visa, MasterCard, Discover, American Express, or CareCredit after 60 days from the date of service.**
- **I agree to pay all reasonable attorney fees and collection costs in the event of default payment of my charges.**
- **I understand that payment of the charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.**
- **I have read and fully understand the above consent for treatment, financial responsibility, and release of my dental information.**

_____ _____

Signature **Date**

1775 Arlington St. Suite 1
Sarasota, FL 34239

T 941 366 1775
F 941 366 1788

www.hvidebergdental.com

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Health History

Patient name: _____ Date of birth: _____

Address _____ Phone_____

Are you currently be treated by a physician for a serious illness? Y / N

If yes, For what? _____

Treating physician: _____ Phone: _____

Are you taking any medication? Y / N If yes, please list here:

_____

For Women Only

Are you taking Birth Control? _____

Are you pregnant? _____

How many weeks? _____

Are you nursing? _____

It is very important that you list ALL the medications you are currently taking. Failure to do so may result in possible drug interactions with the medications used in the office.

Are you Allergic to any medications? Y / N If Yes, What? _____

Have you had or do you have the following?

	YES	NO
High Blood Pressure	○	○
Low Blood Pressure	○	○
Abnormal Bleeding	○	○
Alcohol Abuse	○	○
Allergies	○	○
Anemia	○	○
Angina	○	○
Arthritis	○	○
Artificial heart valves	○	○
Artificial joints	○	○
Asthma	○	○
Blood Transfusion	○	○
Cancer/Chemotherapy	○	○
Colitis	○	○
Cosmetic Surgery	○	○
Congenital heart lesions	○	○
Diabetes	○	○
Drug dependency	○	○
Emphysema	○	○
Epilepsy	○	○
Fainting	○	○
Glaucoma	○	○

	YES	NO
Heart disease	○	○
Hepatitis	○	○
Herpes/cold sores	○	○
HIV/AIDS	○	○
Kidney Problems	○	○
Liver disease	○	○
Mitral Valve Prolapse	○	○
Pacemaker	○	○
Pneumocystis	○	○
Psychiatric Treatment	○	○
Radiation Therapy	○	○
Rheumatic Fever	○	○
Shingles	○	○
Sickle Cell Disease	○	○
Sinus Problems	○	○
Stroke	○	○
Thyroid disease	○	○
Tuberculosis	○	○
Ulcers	○	○
Venereal Disease	○	○
Frequent Headaches	○	○

Any recent illnesses or conditions not listed above?

_____

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Acquaintance Form

Patients Name _____ Date _____

Do you use tobacco products? _____ If yes, how much? _____

Do you see another dentist/specialist regularly? Y / N

If yes, please list name/phone number: _____

When was your last dental cleaning? _____

How often do you go to the dentist? _____

How often do you brush? _____ Electric or Manuel toothbrush? _____

How often do you floss? _____ Traditional or water flosser? _____

Are you having any dental concerns currently? Y / N

If yes, please list: _____

We would like to make your cleanings as comfortable as possible. Please answer this questionnaire so we can make your dental experience as pleasant as possible.

Would you like your hygiene appointment to be a time for you to relax? Y / N

Would you like your hygienist to talk to you during your appointment? Y / N

Would you like to have a neck pillow or blanket during your appointments? Y / N

Do you enjoy having the massage chair turned on during your appointments? Y / N

We have Pandora Internet Radio in our rooms. Would you prefer music on or off? ON / OFF

Do you have a favorite artist or music preference?

Do you find that you tend to have sensitivity in your teeth or gums during cleanings? If so, would you like to have topical anesthetic placed on your gums prior to your cleanings? Y / N

Would you like to have an application of fluoride as a preventive to tooth decay? Y / N

Are you interested in more information about our whitening for life program? Y / N

Any other additional comments / concerns that you would like to share with us? Y / N

If yes, please list: _____

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Our Financial Policy

Thank you for choosing us as your dental care provider. We are fully committed to the successful conclusion of your prescribed dental treatment. Please understand that payment for services rendered is considered an integral part of your treatment. The following is a statement of our **Financial Policy**, which should be read carefully by you and signed prior to any treatment.

Full payment is due at the time of services. We accept cash, check, Visa, MasterCard, Discover, and American Express.

Regarding Insurance:

We will verify your insurance coverage upon your arrival in our office. If we are unable to obtain verification or benefits while you are with us, you may be required to pay in full for that visit. **It is also possible that insurance may cover less than we estimate. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program.** It should be recognized that any balance is your responsibility after 60 days whether your insurance company pays or not.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have fully read, understand, and hereby agree to the policy stated above.

_____ _____

Signature Date

Broken Appointment Policy

Once an appointment is scheduled with Cori S. Hvideberg D.M.D., P.A. a twenty-four (24) hour notice of change or cancelation is required. Calls will be accepted during our regular hours of operation as posted above.

If changing or cancelling an appointment which is scheduled for a Monday, notice must be given to Cori S. Hvideberg, D.M.D., P.A. no later than 4:00pm on the previous Thursday.

Failure to comply with this **Broken Appointment Policy** will void any contracts held with Cori S. Hvideberg D.M.D, P.A. and may also result in a $45 broken appointment charge.

_____ _____

Signature Date

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Notice of Privacy Practices

This notice describe how your health information may be used and disclosed and how you can access this information. Please review it carefully. We have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice. Acknowledgement (effective 4/14/2003)

- We may use or disclose your health information to those involved with your treatment. For example: a review of your record by a specialist doctor, whom we may involve with your care.
- We may disclose your health information for payment of your services. For example: we may send a report of your progress to your insurance company and statements to your home.
- We may use or disclose your health information for your normal healthcare operations. For example: one of our staff members will enter your information into our computer.
- We may share your medical information with our business associates such as billing or insurance services. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example: we may send appointment reminders, call to remind you of appointments, and leave messages.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all your health information when required by law.
- If the practice is sold, your information will become property of the new owner.
- Except as described above, this practice will not use or disclose your health information without prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- You have the right to transfer copies of your health information to another practice.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in you file, please give it to us in writing. We may or may not make the changes you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will not alter earlier documents, but will add new information.
- You have a right to receive a copy of this notice.
- If we change any details of this notice, we will notify you of changes in writing.
- You may file a complaint with the department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy please contact the Privacy Officer at (941)366-1775.

I have read and understand the Notice of Privacy Practices for the office of Cori. S. Hvideberg, DMD, PA

_____ _____

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