Kari Mann DENTAL STUDIO

Dental Implants | Cosmetic Dentistry | Family Dentistry

Welcome to our office. We are committed to providing you with exceptional state of the art dentistry, based on your individual needs and always meeting a standard of care which ensures excellence.

Patient name: _____ **Date of Birth**: _____ **Sex:** _____ **Age**:_____

Driver's License: ____Please Show ID_____ **Social Security Number**: _____ (*necessary for billing purposes)*

Home/Mailing address: _____ **City:** _____ **State**: ____ **Zip**: _____

Home phone: _____ **Cell**:_____ **Email**: _____

Circle Your Preferred Method of Contact for Appointment Reminders: Text Email Home Phone Message Cell Phone Message

Your Occupation: _____ Whom **may we thank for referring you?** _____

Emergency Contact: _____ **Relationship to Patient**: _____ **Phone #**: _____

Name of your previous dentist: _____ **Date of last visit to dentist**: _____

Primary Insurance – Required to Bill Insurance	**Secondary Insurance – Required to Bill Insurance**
Subscribers Name	Subscribers Name
____/____/____ Date of Birth ____ SSN (If different from above)	____/____/____ Date of Birth ____ SSN (If different from above)
Subscribers Relationship to Patient	Subscribers Relationship to Patient
Employer ____ Work Phone #	Employer ____ Work Phone #
Name of Insurance Company	Name of Insurance Company
Group # ____ ID # -Required to bill insurance	Group # ____ ID # -Required to bill insurance

We understand insurance guidelines can be hard to understand and overwhelming at times. Your insurance is a contract between you and your insurance company. We will do our best to assist you in processing your insurance claims. However, your insurance company makes final determination once treatment is completed and the claim is submitted. You are ultimately responsible for the full amount of services rendered.

Signature:_____ Date: _____

3201 Del Prado Blvd S, STE 120 • Cape Coral, FL 33904 • Contact@karimanndentalstudio.com• (239) 542-5335

Kari Mann DENTAL STUDIO

Medical History

Patient Name:_____

Are you under a physician's care now?	Yes	No	Physician's name: _____
History of Serious illness, operation or hospitalization in past 5 years?	Yes	No	If yes: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes: _____
Have antibiotics been recommended prior to dental work being done?	Yes	No	If yes: _____
History of TMJ Disorder? Pain or popping of jaw joints?	Yes	No	If yes: _____
Have you ever been told you have periodontal disease?	Yes	No	If yes: _____

Are you taking Blood Thinners?	Yes	No	If yes what: _____
Are you (or have you) taken medication for Osteoporosis or Paget's disease?	Yes	No	If yes what: _____
History of IV medication to treat metastatic cancer, bone pain, skeletal complications, or multiple myeloma?	Yes	No	If yes what: _____
Are you taking any hormone replacements	Yes	No	If yes what: _____
Do you use any form of tobacco, nicotine, or vaping products?	Yes	No	If yes what: _____
Do you use controlled substances (medicinal or recreationally)	Yes	No	If yes what: _____

Please list any other prescriptions and/or over-the-counter medicines, vitamins, herbs or supplements you are taking:

_____

_____

Women: Are you…. Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Any Allergies to: □ Aspirin □ Penicillin □ Codeine □ Acrylic □ Sulfa drugs □ Local Anesthetics □Hay fever/seasonal allergies □ Metal □ Latex □ Other If yes please explain: _____

Have you ever been diagnosed with Cancer: Yes No If yes please answer the following:
What Type: _____ Date_____
□ Chemotherapy (past or present) □ Radiation Therapy (past or present) □ Treatment On-Going □ In Remission

Heart/Cardiac Health											
Heart Pacemaker	Yes	No	Mitral Valve Prolapse	Yes	No	Congenital Heart Disorder	Yes	No	Heart Trouble/Disease	Yes	No
Heart Failure	Yes	No	High Blood Pressure	Yes	No	Low Blood Pressure	Yes	No	Heart Attack	Yes	No
Heart Mummer	Yes	No	Artificial Heart Valve	Yes	No	Angina/Chest Pain	Yes	No	Arrhythmia/Irregular Rhythm	Yes	No
Stroke	Yes	No	Heart Valve Replacement	Yes	No	Heart Surgery	Yes	No		Yes	No
Blood and Circulatory Health											
Blood Disease	Yes	No	Blood Transfusion	Yes	No	Anemia	Yes	No	Bruises Easily	Yes	No
HIV Positive/AIDs	Yes	No	Sickle Cell Disease	Yes	No	Excessive Bleeding/Hemophilia	Yes	No	High Cholesterol	Yes	No
Lungs											
Emphysema	Yes	No	Breathing Problems	Yes	No	Easily Winded	Yes	No	Asthma/COPD	Yes	No
Lung Disease	Yes	No	Frequent/Chronic Cough	Yes	No	Tuberculosis	Yes	No			
Liver, Kidney, and Digestive Health											
Hepatitis A	Yes	No	Hepatitis B or C	Yes	No	Cirrhosis	Yes	No	Liver Disease/Jaundice	Yes	No
Ulcers	Yes	No	Stomach/Intestinal Disease	Yes	No	Frequent Diarrhea	Yes	No	Acid Reflux/GERD	Yes	No
Diabetes	Yes	No	Hypoglycemia	Yes	No	Kidney Disease	Yes	No	Renal Dialysis	Yes	No
Bone and Joint Health											
Arthritis	Yes	No	Gout	Yes	No	Rheumatoid Arthritis	Yes	No	Osteoporosis	Yes	No
Brain (Neurological)/Mental Health											
Anxiety/Depression	Yes	No	Mental Health Disorder	Yes	No	Under Psychiatric	Yes	No	Alzheimer's Disease	Yes	No
Dementia	Yes	No	Epilepsy or Seizures	Yes	No	Frequent Headaches	Yes	No	Fainting/Dizziness		
Other											
Hives or Rash	Yes	No	Sinus Trouble	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters		
Cortisone Medicine	Yes	No	Drug Addiction	Yes	No	Herpes	Yes	No	Shingles		
Swelling of Limbs	Yes	No	Rheumatic Fever	Yes	No	Autoimmune Condition	Yes	No	Immune Deficiency		
Thyroid Disease	Yes	No	Parathyroid Disease	Yes	No	Sexually Transmitted Disease	Yes	No	Tumors or Growths		
Organ Transplant	Yes	No	Artificial Joint	Yes	No						

To the best of my knowledge, these questions have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date:_____

Relationship to Patient: _____ Printed name:_____

Kari Mann DENTAL STUDIO
Dental Implants | Cosmetic Dentistry | Family Dentistry

OFFICE AND FINANCIAL POLICY

Thank you for choosing Kari Mann DDS PLLC as your dental care provider. Our office is committed to providing you with the highest quality dental care. We strive for transparency in our policies in order to better assist you in navigating the financial portion of your dental care. Please understand that payment of your bill is considered as part of your treatment. ***Please discuss available options with our staff to find the solution that is best for you.***

DENTAL INSURANCE BENEFITS:

Our practice is committed to providing the highest quality dental care for our patients. It is our responsibility to provide You the treatment that best meets your needs, not to try and match your care to your insurance plan and its limitations. Dental Insurance is different from medical insurance and often falls short of covering the costs of your dental treatment needs. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. We recognize that understanding your dental plan and its limitations can be confusing. Our team will do our best to assist you in understanding your plan and maximizing the benefits you have available. We will not recommend treatment based solely on your limited insurance coverage as this can result in treatment that falls below the current standard of care.

If you wish for us to bill your insurance as a courtesy, on your behalf, your complete insurance information must be presented prior to services being provided. Insurance claims cannot be backdated. By providing this information and signing this document, you agree to have Kari Mann DDS PLLC submit insurance claims on your behalf.

Your insurance policy is a contract between you and your insurance company. We are not privy to that contract. As a courtesy to our patients we can assist you in interpreting your dental insurance benefits to the best of our abilities. We cannot make any guarantees on accuracy or comprehensiveness of the information we are provided. ***You are ultimately responsible to know your plan coverage, exclusions and limitations.*** You should familiarize yourself with the rollover/renewal date for your plan, non-covered benefits and limitations including but not limited to following examples: missing teeth clause, crown/bridge/denture restorations, bruxism, downgraded limitations for fillings and crowns, and frequency limitations for procedures. Our team will do our best to answer any questions you may have, but your insurance member services is the best resource to assist you in fully understanding your plan benefits.

You will be provided a treatment plan estimate for restorative services, this is only an **estimate** based on our best information. It is possible that treatment needs may change in the course of treatment. We deliver the highest quality of care at the most reasonable cost to our patients; therefore payment is due at the time services are rendered unless other arrangements have been made in advance.

PAST DUE AMOUNTS AND FINANCE CHARGES:

All returned checks are subject to a $35 fee. All balances over 60 days are subject to compound interest in the amount of 1.5% per month. We reserve the right to apply a $25 rebilling fee and a $25 late charge, for any overdue payments. Any accounts over 90 days past due will be turned over to a collection agency or attorney, you will be responsible and agree to pay all fees including but not limited to attorney fees, court costs and collection agency fees.

Initial _____

3201 Del Prado Blvd S, STE 120 • Cape Coral, FL 33904 • Contact@karimanndentalstudio.com• (239) 542-5335

Kari Mann DENTAL STUDIO
Dental Implants | Cosmetic Dentistry | Family Dentistry

OFFICE AND FINANCIAL POLICY

FAILED APPOINTMENT/LATE CANCELATION FEE:
Your appointment is time that Dr. Mann and our team has specially reserved for you. We consider the time set aside for your appointment to be yours alone and important for your health. For this reason, we never double book our schedule or accept drop-ins, except in emergencies. ***We require 48 BUSINESS hour's notice to change or reschedule an appointment***. Exceptions to this policy will be made on a case-by-case basis depending on individual circumstances. We charge a fee of **$75 per hour of the appointment time scheduled** for all appointments missed or canceled without 48 business hours notice. Please call us immediately once you realize that you require a change in schedule.

DEPOSITS:
Certain services we provide require special preparation and/or extended appointment times. For these services we do require a deposit to reserve a time on our schedule for these procedures. This deposit will go towards the cost your treatment on the day services are rendered provided your appointment time is maintained or proper notice is given to move or change this appointment. In the event that the reserved appointment time is missed or moved without **48 business hours notice,** your missed/failed appointment fee will be taken out of the deposit, with exception to individual circumstances on a case-by-case basis.

APPOINTMENT AND OFFICE NOTIFICATIONS:
Our team does our best to communicate with our patients through phone, text and email. Through these services you will also receive confirmations and reminders. You do have the option to opt out of these communications, but we do not recommend it. Doing so will remove you from ALL notifications and you will miss important information our office sends out including any confirmations and/or reminders about your appointments. Please note all calls incoming and outgoing through our office are recorded.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY. ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I AGREE TO ABIDE BY THIS FINANCIAL POLICY.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Kari Mann DENTAL STUDIO
Dental Implants | Cosmetic Dentistry | Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Kari Mann Dental Studio. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Kari Mann Dental Studio reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY OR CLOSE RELATIONS

In addition to the allowable disclosures described in the statement of privacy practices, I hereby specifically authorize disclosure of my Protected Health Care information to the person(s) identified below. I understand that unless I identify specific persons below, personal protected information cannot be shared or discussed with anyone unless otherwise allowed by HIPAA rules.

Spouse (Name) _____	○ Yes ○ No
Any member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	○ Yes ○ No
Any member of my extended family: (i.e Parents, Grandchildren, etc.)	○ Yes ○ No
Other (Name) _____ Relationship _____	○ Yes ○ No

Unless otherwise instructed we will contact you regarding appointments and billing at the number(s), email(s), and addresses provided. We may leave messages or texts on those devices.

Patient's Name: _____

Signature: _____ Date: _____
(Patient or Parent/Legal Guardian)

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Parent/Legal Guardian Name_____**Relationship to Patient:** _____

Kari Mann DENTAL STUDIO
Dental Implants | Cosmetic Dentistry | Family Dentistry

MEDIA AND ADVERTISING RELEASE

I understand that Kari Mann Dental Studio, its employees, agents, and representatives, may take photographs and/or videos of me during my visit(s) to their office for clinical practice. From time to time they may wish to utilize these for the purpose of marketing, advertising, and promoting the dental practice in media and on various platforms, including but not limited to websites, social media channels, print materials, and digital advertisements.

I understand that these photos and/or videos may be used for promotional purposes to highlight the services and atmosphere of **the practice.** I also acknowledge that I will not receive compensation for the use of my image in such media and advertising materials.

_____I confirm that I have provided my consent voluntarily and without any form of coercion for Kari Mann Dental Studio to utilize my photos in marketing. I understand that my image displaying my full face may be edited, reproduced, and distributed by **Kari Mann Dental Studio.**

This release shall remain in effect unless revoked in writing. Should I choose to revoke this authorization, such revocation will apply only to future uses and not to materials already produced.

_____I do not wish to authorize Kari Mann Dental Studio to utilize my photos or videos outside of clinical application or teaching applications.

Patient Name: _____

Signature: _____

Date: _____

For any questions or concerns regarding the use of my image, I can contact **Kari Mann Dental Studio**

contact@karimanndentalstudio.com **or 239-542-5335**