CHRISTIE LATULIPPE, DMD
821 Big Tree Rd
South Daytona, FL 32119
(386) 767-8383

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date 08/22/2024

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced Preferred Appointments _____

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____ What's the best way to reach you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Birthdate _____ Currently a patient in our office? ☐ Yes ☐ No

Employer _____ Work Phone _____

E-Mail _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have or have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collecting between the teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Have you ever had any serious illnesses or operations?? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had problems with any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Anemia	☐	☐	Congenital Heart lesions	☐	☐	Hepititis	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cortisone Treatments	☐	☐	Hernia Repair	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Skin Rash
☐	☐	Artificial Joints, Pins, etc.	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Swelling of Feet or Ankles
☐	☐	Back Problems	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Bleeding Abnormally	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Rheumatic fever			

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Local Anesthetic	☐	☐	Iodine	☐	☐	Other _____
☐	☐	Barbiturates (Sleeping Pills)	☐	☐	Penicillin	☐	☐	Latex			_____
☐	☐	Codeine	☐	☐	Sulfa	☐	☐	None			

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

_____ _____

Signature of of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

FINANCIAL AGREEMENT

Thank you for choosing BIG TREE DENTAL & DR. CHRISTIE LATULIPPE as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General:
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS:
Unless we receive notice of cancellation 48 hours in advance, you will be charged $50.00. Please help us service you better by keeping scheduled appointments.

INSURANCE:
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:
FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

We accept CASH, CREDIT CARDS, CHECKS & CARE CREDIT.

Unpaid balance over 30 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature: _____

Date:_____

HIPAA Compliance & Acknowledgement
Patient Consent Form

Our Notice Of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your dental conditions with any member of your family? YES NO

If YES, please name the family members allowed:

_____

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____Date: _____