

Michael S. Gorfinkel, D. M. D.
Pine Island Office Centre
111 North Pine Island Road, Suite 101
Plantation, Florida 33324
(954) 473-6500

Acknowledgement of receipt of the Notice of Privacy Practices:

I have received the notice of Privacy Practice _____

I give my consent to disclose my personal information to other healthcare providers or insurance companies _____

If you would like to see a complete HIPAA package, please ask Sharon.

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR HOME # WORK #

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

Has any member of your family ever been treated in our office? YES NO

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

FILL IN BOTH SHADED BLOCKS FOR MINOR CHILD.
 FILL IN APPROPRIATE SHADED BLOCK FOR ADULT.

PERSON RESPONSIBLE FOR ACCOUNT

LAST _____ FIRST _____ M _____
 STREET _____ CITY _____ STATE _____ ZIP _____
 HOME TELEPHONE # _____ WORK TELEPHONE # _____
 BIRTH DATE (MO/DAY/YEAR) _____ SS # _____
 EMPLOYER _____ DL # _____
 DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

SPOUSE INFORMATION

LAST _____ FIRST _____ M _____
 STREET _____ CITY _____ STATE _____ ZIP _____
 HOME TELEPHONE # _____ WORK TELEPHONE # _____
 BIRTH DATE (MO/DAY/YEAR) _____ SS # _____
 EMPLOYER _____ DL # _____
 DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household
 Name _____
 Address _____
 City/State/ZIP _____
 Telephone # _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One
 Patient Father (or Husband)
 Guardian Mother (Or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office
 YES NO
 Payment in full at each appointment (cash or personal check)
 Payment in full at each appointment (VISA MC Disc.)
 Card # _____ Exp. Date _____
 I wish to discuss the Dental Office's Financial Policy/
 Payment Arrangements

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X Adult Patient Father (Or Husband) Mother (Or Wife) Guardian

Date _____ State Driver's License # _____

SERVICE/COLLECTION CHARGES
 If I do not pay the entire balance within twenty-five (25) days of the monthly billing date, I agree to pay a late charge to cover collection costs equal to the higher of ten percent (10%) of any such late payment or \$25.00 dollars, but not more than the highest legal rate of interest. To the extent allowed by law, any late payment will continue to accrue interest at the lower of 1.5% per month (18% per year) or the highest legal rate from the due date until paid, unless prior arrangements are made.
 Notwithstanding the above, I promise to pay any and all collection charges and service charges as stated above together with any and all additional collection costs and attorney's fees incurred to effect collection of any amounts or monies I owe for services rendered on this account or for future outstanding accounts.

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No

Do you have dental examinations on a routine basis? Last visit _____ Yes No

Do you think you have active decay or gum disease? _____ Yes No

Do you brush and floss on a routine basis? Discuss _____ Yes No

Do your gums ever bleed? Discuss _____ Yes No

Do you like your smile? Why? _____ Yes No

Does food catch between your teeth? Any loose teeth? _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No

Have your past experiences in a dental office always been positive? _____ Yes No

Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No

Name of previous dentist (optional): _____

Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Name _____ Phone # _____ Yes No

Reason? _____

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications, pills or drugs? What? _____ Yes No

Are you on a special diet? Discuss _____ Yes No

Are you allergic to any medications or substances? Please check box below Yes No

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

WOMEN (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
 * If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina/Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	X-Ray Treatments (Radiation)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia (Bleeding Problem)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joint*/Implant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pace Maker *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Surgery *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Medicines)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A (Infectious)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Pollens/Dust)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings: _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	Dr. _____

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Payment Arrangements

In general, payment is due upon service rendered. The exceptions to this is:

- Patients who have made prior financial arrangements due to an extended treatment plan.
- Patients who have dental insurance.

For the patients who have dental insurance—*Please read:*

We are happy to file your dental insurance for you. We do this as a courtesy for you. At the time of service, you are responsible for the portion of the fee your insurance does not cover. We can only estimate what this will be, and any balance left over after the insurance payment is your responsibility.

Please be aware that there are times that the insurance company leads us to believe a service will be covered at a specific percentage, but they end up not covering it at all or covering it at a lower percentage. This is allowable and determined by your insurance company. This is not our fault and we cannot absorb the difference.

Please remember, if you have dental insurance, this is a contractual agreement between you and your insurance company. We are not part of that contract.

Our responsibility is to provide you with the highest quality dental care available.

Please sign: _____