Raynald Michel D.D.S.

General & Cosmetic Dentistry

3051 N. Federal Highway • Fort Lauderdale, FL 33306

New Patient Package

Welcome! We are so pleased you have chosen our practice for your dental care. Please complete all forms carefully and thoroughly. Your responses allow us to provide you with the safest and most personalized treatment possible.

This Package Contains
1. Health History Form (ADA)
2. Appointment & Cancellation Policy
3. HIPAA Compliance Patient Consent Form
4. Insurance Policy & Financial Responsibility
5. Photography / Social Media Consent Release

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Health History Form

American Dental Association • Form S500

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you. Your answers are for our records only and will be kept confidential subject to applicable laws. This information is vital to allow us to provide appropriate care for you.

Patient Information

Today's Date | Email Address

Last Name | First Name | Middle Initial

Home Phone | Business / Cell Phone

Street Address | City | State | Zip

Date of Birth | Sex (M / F)

SS# / Patient ID | Emergency Contact | Relationship | Cell Phone

Preferred Pharmacy

Pharmacy Name | Phone Number

Street Address | City | State | Zip

Tuberculosis Screening

If you answer Yes to any item below, please stop and return this form to the receptionist.

Active Tuberculosis	Yes	No	DK
Persistent cough greater than a 3-week duration	Yes	No	DK
Cough that produces blood	Yes	No	DK
Been exposed to anyone with tuberculosis	Yes	No	DK

Dental Information

Reason for today's visit

How do you feel about your smile?

Date of last dental exam | What was done at that time?

Date of last dental X-rays

Dental Health Questions

Do your gums bleed when you brush or floss?	Yes	No	DK
Are your teeth sensitive to cold, hot, sweets or pressure?	Yes	No	DK

Health History Form (continued)

Medical Information

Are you now under the care of a physician? Yes No DK

Physician Name | Phone | Address / City / State / Zip

Are you in good health? Yes No DK

Has there been any change in your general health within the past year? Yes No DK

If yes, what condition is being treated?

Date of last physical exam

Have you had a serious illness, operation or been hospitalised in the past 5 years? Yes No DK

If yes, describe the illness or problem

Are you taking or have you recently taken any prescription or over-the-counter medicines? Yes No DK

List all medications (including vitamins, herbal, dietary supplements)

Allergies — Are you allergic to or have you had a reaction to:

Local anesthetics	Yes	No	Aspirin	Yes	No
Penicillin or other antibiotics	Yes	No	Barbiturates, sedatives, or sleeping pills	Yes	No
Sulfa drugs	Yes	No	Codeine or other narcotics	Yes	No
Metals	Yes	No	Latex (rubber)	Yes	No
Iodine	Yes	No	Hay fever / seasonal	Yes	No
Animals	Yes	No	Food	Yes	No
Other	Yes	No			

Please describe any reactions

Health History Form (continued)

Medical Conditions (check all that apply)

☐ Cardiovascular disease	☐ Angina	☐ Arteriosclerosis	☐ Congestive heart failure
☐ Damaged heart valves	☐ Heart attack	☐ Heart murmur	☐ Low blood pressure
☐ High blood pressure	☐ Congenital heart defects	☐ Mitral valve prolapse	☐ Pacemaker
☐ Rheumatic fever	☐ Rheumatic heart disease	☐ Abnormal bleeding	☐ Anemia
☐ Blood transfusion	☐ Hemophilia	☐ AIDS or HIV infection	☐ Arthritis
☐ Autoimmune disease	☐ Rheumatoid arthritis	☐ Systemic lupus	☐ Asthma
☐ Bronchitis	☐ Emphysema	☐ Sinus trouble	☐ Tuberculosis
☐ Cancer / Chemo / Radiation	☐ Chest pain on exertion	☐ Chronic pain	☐ Diabetes Type I or II
☐ Eating disorder	☐ Malnutrition	☐ Gastrointestinal disease	☐ G.E. Reflux / heartburn
☐ Ulcers	☐ Thyroid problems	☐ Stroke	☐ Glaucoma
☐ Hepatitis / liver disease	☐ Epilepsy	☐ Fainting / seizures	☐ Neurological disorders
☐ Sleep disorder	☐ Snoring	☐ Mental health disorders	☐ Recurrent infections
☐ Kidney problems	☐ Night sweats	☐ Osteoporosis	☐ Swollen glands in neck
☐ Severe headaches / migraines	☐ Severe / rapid weight loss	☐ Sexually transmitted disease	☐ Excessive urination

Lifestyle

Do you use controlled substances (drugs)? Yes No DK

Do you use tobacco (smoking, snuff, chew)? Yes No DK

Do you drink alcoholic beverages? Yes No DK

If yes to alcohol, how much per week?

Women Only

Pregnant? Yes No DK

Number of weeks

Taking birth control pills or hormonal replacement? Yes No DK

Nursing? Yes No DK

Antibiotic Prophylaxis / Additional Information

Has a physician or previous dentist recommended you take antibiotics prior to dental treatment? Yes No DK

Name of physician or dentist

Phone

Do you have any disease, condition, or problem not listed above that we should know about? Yes No DK

Please explain

Health History Form (continued)

I certify that I have read and understand the above and that the information given is accurate. I understand the importance of a truthful health history and that my dentist and staff will rely on this information for treating me.

Signature of Patient / Legal Guardian

Date

Signature of Dentist

Date

Appointment & Cancellation Policy

Thank you for choosing our office for your dental care.

When an appointment is scheduled, dedicated time is reserved specifically for you. We kindly request at least 48 business hours notice if you need to cancel or reschedule your appointment.

Missed appointments, late cancellations, or repeated rescheduling may result in:

- A cancellation / no-show fee of $55
- A deposit requirement for future appointments
- Limited scheduling privileges for repeated occurrences

Please understand that preparation for your visit may include reserving clinical time, preparing records, coordinating staff, and setting up instruments and materials specifically for your treatment.

We value your time and respectfully ask for the same courtesy in return.

Patient Name (Print)	Signature	Date

HIPAA Compliance 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 confirm 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 and 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 honour this agreement. HIPAA (Health Insurance Portability and Accountability Act of 1996) 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 and potentially anonymous usage in a publication. You have the right to revoke this consent in writing. 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 is not required to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time; future disclosures will then cease except as otherwise permitted or
- The practice may condition receipt of treatment upon execution of this consent.

Communication Preferences

May we phone, email, or send a text to confirm appointments?	Yes	No	DK
May we leave a message on your answering machine or cell phone?	Yes	No	DK
May we discuss your medical condition with any member of your family?	Yes	No	DK

If YES, please name the family members allowed

Signature | Date | Witness | Date

This consent was signed by (PRINT NAME)

Insurance Policy & Financial Responsibility

We are pleased to assist you in filing your dental insurance claims as a courtesy to you. However, we want to make sure you understand the nature of your insurance benefits and your financial responsibility as our patient.

Insurance is a Contract Between You and Your Insurer

Your dental insurance policy is a contract between you and your insurance company. Raynald Michel D.D.S. is not a party to that contract. Benefits are determined solely by your insurance carrier based on the terms of your individual policy.

Patient Financial Responsibility

You are responsible for any and all balances not paid by your insurance company. This includes, but is not limited to, deductibles, co-payments, non-covered services, and amounts exceeding your annual maximum benefit.

Estimates Are Not Guarantees

Any estimate of insurance benefits provided by our office is a courtesy only and is not a guarantee of payment. Final benefit determinations are made by your insurance company after the claim is processed.

Payment of Balance

Any remaining balance is due upon receipt of your insurance Explanation of Benefits (EOB). If your insurance company has not responded within 60 days, the full balance becomes the responsibility of the patient.

By initialling below, I acknowledge that I have read and understand the above insurance and financial responsibility policy. I agree to pay any balance not covered by my insurance company.

Patient Initials	Patient Name (Print)	Date

Photography / Social Media Consent Release

I hereby authorise Dr. Raynald Michel, DDS to take photographs and/or videos of my face, jaws and teeth, before, during and after treatment. I understand that the photographs and/or videos will be used as a record of my care, and may be used for advertising purposes (including website publication, Facebook / Instagram posts, etc.)

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential (other than if full-face photographs are used). I do not expect compensation, financial or otherwise, for the use of these photographs.

If declining this consent, leave blank.

Please initial one option:

Initials	Option
	I do not mind if my photographs are used in any of the situations described above.
	I only agree to have my teeth shown without any identifying features.

Patient Signature

Date

Thank you for completing your new patient paperwork. We look forward to caring for your smile!