PARSONS
FAMILY DENTAL
Experience You Trust, Care You Deserve

CONTACT
921 S Parsons Ave, Brandon, FL 33511
(813) 278-8515
info@parsonfamilydental.com

WELCOME & OFFICE POLICIES

Welcome to Parsons Family Dental. We are genuinely pleased that you have chosen us for your dental care. Our team is committed to earning your confidence by providing comfortable, compassionate, and up-to-date dental care.

APPOINTMENT POLICY

Please make every effort to keep your scheduled appointments. Missed appointments can disrupt the proper sequence of care and delay completion of treatment. If you need to reschedule, please call at least 24 hours before your appointment. Monday appointments must be changed by Thursday at 12:00 p.m.

If you arrive more than 10 minutes late, we will evaluate the schedule to determine whether you can still be seen. In some cases, you may be asked to reschedule. Broken appointments may be charged at a rate of $85 per hour. Repeated missed appointments may result in dismissal from the practice.

INSURANCE & FINANCIAL POLICY

As a courtesy, we will submit claims to your insurance company. Insurance benefits vary, and you are responsible for understanding your plan. Any estimated patient portion is due as treatment is rendered. If a balance remains, a billing notice will provide 10 business days for payment. I understand that any amount not paid by insurance, including claims unpaid after 60 days, is my responsibility.

☐ I authorize my insurance company to pay its portion directly to Parsons Family Dental.

☐ I choose to pay the full fee when services are rendered and submit my own claim for reimbursement.

PAYMENT AUTHORIZATION (OPTIONAL)

Cardholder Name _____ Last 4 Digits _____ Exp. _____

For security, do not write the full card number or security code on this form. The office can securely collect payment details.

I HAVE READ, UNDERSTAND, AND AGREE TO THE POLICIES ABOVE.

Printed Name _____ Date _____

Signature _____

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PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Parent/Guardian (if minor) _____ Preferred Name _____

Street Address _____

City _____ State _____ ZIP Code _____

Mobile Phone _____ Home Phone _____ Email _____

Driver's License _____ Age _____ Sex _____ Marital Status _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

VISIT INFORMATION

Reason for Visit _____

Referred By _____ Person Responsible for Payment _____

A parent or guardian accompanying a minor is responsible for payment.

INSURANCE INFORMATION

☐ I have dental insurance. ☐ Policy is through my employer. ☐ Policy is through my spouse/other.

Insurance Company _____ Group Number _____

Insurance Phone _____ Member/Policy ID _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber Employer _____ Relationship to Patient _____

Claims Address _____

PAYMENT INFORMATION

Payment is expected at the time of treatment. We accept cash, personal checks, Visa, Mastercard, American Express, Discover, and CareCredit. A fee may be charged for returned checks.

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MEDICAL HISTORY

PHYSICIAN & GENERAL HEALTH

Physician Name _____ Phone _____

Date of Last Medical Exam _____ Hospitalized in Past 5 Years? _____

If Yes, Please Explain _____

HEALTH CONDITIONS - CHECK ALL THAT APPLY

- ☐ Anemia
- ☐ Heart Condition
- ☐ High/Low Blood Pressure
- ☐ Diabetes
- ☐ Lung Condition
- ☐ Mononucleosis
- ☐ Hepatitis
- ☐ Kidney Condition
- ☐ Heart Murmur
- ☐ HIV/AIDS
- ☐ Pregnant or Nursing
- ☐ Bleeding Disorder

Other Conditions _____

ALLERGIES

- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Latex
- ☐ Other Medication/Drug

Please Describe Allergies or Reactions _____

MEDICATIONS & CURRENT CARE

Current Medications (include dosage) _____

Current Medical Care / Reason _____

☐ I authorize the practice to request relevant medical records when needed for my care.

AUTHORIZATION

I authorize Dr. Farrokhrooz and Parsons Family Dental to release relevant treatment information to third-party payers and healthcare practitioners as permitted. I authorize direct payment of insurance benefits to the dentist. I understand that insurance may pay less than the actual fee and that I am responsible for services provided to me or my dependent.

Patient/Guardian Signature _____ Date _____

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PATIENT CONSENT FORM (HIPAA)

I understand that I have rights regarding the privacy of my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this consent, I authorize Parsons Family Dental to use and disclose my protected health information as permitted for:

- Treatment, including coordination with other healthcare providers involved in my care.
- Payment activities, including obtaining payment from third-party payers such as my insurance company.
- The day-to-day healthcare operations of the practice.

I acknowledge that I have been informed of my right to review and obtain a copy of the practice's Notice of Privacy Practices, which more fully describes uses and disclosures of my protected health information and my rights under HIPAA. I understand that the practice may revise the notice and that I may request the current version at any time.

I may request restrictions on how my protected health information is used or disclosed for treatment, payment, and healthcare operations. I understand that the practice is not generally required to agree to a requested restriction, except when otherwise required by law. If the practice agrees to a restriction, it will comply with that restriction.

I understand that I may revoke this consent in writing at any time. Revocation will not affect any use or disclosure made before the practice received my written revocation.

ACKNOWLEDGMENT & CONSENT

☐ I acknowledge that I was offered a copy of the Notice of Privacy Practices.

Patient Name _____

Relationship to Patient (if applicable) _____

Signature _____ Date _____

OFFICE USE ONLY

Received By _____ Date _____