Welcome!

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that last a lifetime. Please visit us at www.towncaredental.com

1 Patient Information

Today's Date _____

First Name _____ MI _____

Last Name _____

Birthdate _____ Age ____ SS# _____

☐ Married ☐ Single ☐ Widowed ☐ Divorce ☐ Separated

Address _____

_____

Home # _____ Cell # _____

Employer _____ Work # _____

Occupation _____

Email _____

Referred by _____

2 Responsible Party

First Name _____ MI _____

Last Name _____ ☐ M ☐ F

Birthdate _____ Age ____ SS# _____

Employer _____ Work# _____

Occupation _____

Employer's Address _____

_____

3 Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy _____

Policy Owners Name _____

Relationship to Patient _____

Policy Owners Birthdate _____ SS# _____

Policy Owners Employer _____

Employees Address _____

Orthodontic Coverage? ☐ Yes ☐ No

4 Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy

Policy Owners Name _____

Relationship to Patient _____

Policy Owners Birthdate _____ SS# _____

Policy Owners Employer _____

Employees Address _____

Orthodontic Coverage? ☐ Yes ☐ No

5 Dental History

Purpose of todays visit _____

Previous dentist _____

When was your last visit _____

What was done _____

Last Cleaning _____

How often do you brush _____ Gums bleed ☐ Yes ☐ No

Any ☐ Sensitive teeth ☐ Loose teeth ☐ Broken Fillings ☐ Jaw pain ☐ Injuries to teeth

Explain _____

Unpleasant Dental Experience ☐ Yes ☐ No

Explain _____

Have you ever had ☐ Orthodontics ☐ Gum Treatment ☐ Root Canal ☐ Oral Surgery ☐ Crowns ☐ Veneers ☐ Implants

Are you happy with the appearance of your teeth?
☐ Yes ☐ No ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ☐ Yes ☐ No
☐ In Office ☐ Overnight ☐ Drug Store

Are you interested in replacing any missing teeth? ☐ Yes ☐ No
Which method ☐ With Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ☐ Yes ☐ No

(please continue on back)

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with _____ (NAME OF PATIENT). I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed fit to provide recommended treatment.

6 Medical History

Physicians Name _____

Office Address _____

Telephone _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Explain _____

Has there been a recent change to your health? ☐ Yes ☐ No

Explain _____

Are you currently taken any prescription, over the counter of recreational drugs? ☐ Yes ☐ No

Explain _____

Have you been hospitalized or had a serious illness within the past five years? ☐ Yes ☐ No

Explain _____

Please mark any allergies/adverse reactions:

Y N Penicillin
Y N Tetracycline
Y N Erythromycin
Y N Sulfa
Y N Local Anesthetics
Y N Codeine
Y N NSAID (Advil/Motrin)
Y N Aspirin
Y N Valium
Y N Barbiturates
Y N Latex
Y N Iodine
Y N Household Bleach
Other _____

Do you?

☐ Smoke Packs Per Day?_____How Long? _____
☐ Chew Tobacco
☐ Drink Per Week?_____Per Month?_____
☐ Wear Contact Lenses
☐ Take Diet Pills ☐ Take Herbal Supplements

Check if you have or ever had

Y N Artificial Limb/joint/hip
Y N High/low Blood Pressure
Y N Organ Transplant
Y N Sinus Problems
Y N Migraines
Y N Frequent Headaches
Y N Claustrophobia
Y N Artificial Heart Valve
Y N Prolonged Bleeding
Y N Ulcers/colitis
Y N Hay Fever
Y N Head Injury
Y N Venereal Disease
Y N Mitral Valve Prolapse
Y N Anemia
Y N Acid Reflux
Y N Arthritis
Y N Epilepsy/seizures
Y N STD
Y N Rheumatic Fever
Y N Radiation Therapy
Y N Stomach Problems
Y N Glaucoma
Y N Dizziness/Fainting Spells
Y N Treated For AIDS, HIV, ARC
Y N Heart Murmur
Y N Thyroid Problems
Y N Used Phen Phen
Y N Chronic Diarrhea
Y N Stroke TIA
Y N Joint Surgery
Y N Cancer/chemotherapy
Y N Blood Disorder
Y N Increased Frequent Urination
Y N Bells Palsy
Y N Heart Disease
Y N Diabetes
Y N Asthma
Y N Night Sweats
Y N Psychiatric Or Emotional
Y N Recurrent Infections
Y N Angina
Y N Kidney Problems
Y N Bronchitis
Y N Addictions
Y N Pace Maker
Y N Liver Problems
Y N Emphysema
Y N TMJ Problems
Y N Shortness Of Breath
Y N Hepatitis: A or B or C
Y N Tuberculosis
Y N Unexplained Weight Loss
Y N Mouth Ulcers

7 Office Policy

We reserve the right to charge for any cancelled appointments if we do not receive 48 hours notice. All accounts sent to collections will be charged the account balance plus an additional 50% based on the account balance. Regardless of insurance, patients are fully responsible for any account balance. Patients are encouraged to ask all relevant dental & medical questions and thus fully understand the cost, time, limitations, and potential complications of any dental care they agree to receive. The dental profession can not be responsible for any treatment failures that are the result of patient neglect, injury or abuse. By my signature I hereby do certify that: I have read and understood the office policy. All information I have provided is accurate. I will update the office regarding any changes in this information. I will not hold any member of the dental staff responsible for actions resulting from any errors or omissions that I have made in the completion of this form. *Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.* I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his or her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003 and will remain in effect until we replace it.

Accept Assignment: My signature authorizes the release of necessary information needed to process my claim, and to pay benefits to the provider of service.

_____ SIGNATURE OF PARENT OR GUARDIAN DATE

8 For Completion By Dentist

Comments on patient interview concerning health history

_____

_____

_____

Significant findings from questionnaire or oral interview

_____

_____

_____

Dental Management considerations

_____

_____

_____ SIGNATURE OF DENTIST DATE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/15/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician/dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We may from time to time contact you by mail or phone to update you on information that may be pertinent to your dental health unless you state in writing otherwise.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Correspondence: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters), birthday cards, or recall cards, and missed appointment notification.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. **(You must make a request in writing to obtain access to your health information.)** You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you for duplication of your records and x-rays.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

B. PERMISSION TO USE INFORMATION

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices. I give this office permission to use my health information to treat me as outlined on the back of this form.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Please Note: Under current Florida Law we have the right to refuse to treat you if you do not sign this form. We will inform you if we choose that option.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW IT CAREFULLY.

Health-care Treatment, Payment and Operations Rule With your signed Consent, we may use or disclose your PHI in order:

- To provide you with or coordinate health-care treatment and services. For examples, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other health-care providers, scheduled lab work for you, etc.

- To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance converge, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations form your health plan or provide your x-rays because your health plan requires them for payment.

- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce cost associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave a message with whomever answers your telephone or e-mail to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, we may tell you about or recommend health-related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our privacy officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes.