PLEASE PRINT

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

| PATIENT'S LEGAL NAME LAST, FIRST MI | DATE OF BIRTH | SEX | SOCIAL SECURITY # |
|---|---|---|---|
| | | | |

| PREFER TO BE CALLED | HOME PHONE # | CELL PHONE # |
|---|---|---|
| | | |

| PATIENT'S ADDRESS STREET APT# CITY STATE ZIP | E-MAIL |
|---|---|
| | |

| MARITAL STATUS<br>☐ S ☐ M ☐ W ☐ D<br>☐ UNDER AGE 18 | PATIENT'S / GUARDIAN'S EMPLOYER | OCCUPATION |
|---|---|---|
| | | |

| WORK ADDRESS STREET APT# CITY STATE ZIP | WORK PHONE # |
|---|---|
| | |

| SPOUSE'S NAME LAST, FIRST MI | SPOUSE'S EMPLOYER | OCCUPATION |
|---|---|---|
| | | |

| SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP | WORK PHONE # |
|---|---|
| | |

| OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? |
|---|---|
| | |

# EMERGENCY CONTACT INFORMATION

## PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

| NAME | RELATIONSHIP |
|---|---|
| | |

| HOME PHONE # | WORK PHONE # | CELL PHONE # |
|---|---|---|
| | | |

# REQUEST FOR CONFIDENTIAL COMMUNICATION

## AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

| | YES | NO |
|---|---|---|
| Contact me at home | ☐ | ☐ |
| Contact me via cell phone | ☐ | ☐ |
| Contact me at work | ☐ | ☐ |
| Contact me via e-mail | ☐ | ☐ |
| Leave messages on my home voicemail / answering machine | ☐ | ☐ |
| Leave messages on my cell phone voicemail | ☐ | ☐ |
| Leave messages on my work voicemail / answering machine | ☐ | ☐ |

PLEASE PRINT

# INSURANCE AND FINANCIAL INFORMATION

| INSURANCE COVERAGE ☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | INSURANCE PHONE |
|---|---|---|---|
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S BIRTHDAY | SUBSCRIBER'S SSN / ID # |
| GROUP / PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | EMPLOYER'S ADDRESS | |

| SECONDARY COVERAGE ☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | INSURANCE PHONE |
|---|---|---|---|
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S BIRTHDAY | SUBSCRIBER'S SSN / ID # |
| GROUP / PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | EMPLOYER'S ADDRESS | |

# RELEASE INFORMATION

## YOU MAY DISCUSS MY HEALTHCARE WITH

| | YES | NO | OTHERS (PLEASE PRINT) |
|---|---|---|---|
| Health Care Providers | ☐ | ☐ | 1. |
| Insurance Companies | ☐ | ☐ | 2. |

# CONFIRMATIONS

## DO YOU PREFER A CONFIRMATION CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

# ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

| SIGNATURE - PATIENT / GUARDIAN | DATE |
|---|---|
| WITNESS SIGNATURE | DATE |

# MEDICAL/DENTAL QUESTIONNAIRE

**Patient Name**_____ **Date** _____

Please review the information and answer all questions to the best of your knowledge. Understand this information will be used to determine the dental treatment you receive at this office and may be shared with other medical offices only as necessary. Please will notify the office should any information change in the future.

**Please check if you have any of the following:**

- ☐ AIDS / HIV Positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer

Describe_____

- ☐ Chemotherapy
- ☐ Circulation problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart, any problems

Describe_____

_____

- ☐ Hemophilia
- ☐ Herpes
- ☐ Hepatitis, Type: A B C
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Seizure disorders
- ☐ Shingles
- ☐ Skin rash
- ☐ Stroke
- ☐ Surgical implants
- ☐ Swelling, feet or ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Ulcers/colitis

**Known Allergies:**

- ☐ Local anesthetic
- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Iodine
- ☐ Latex
- ☐ Other: _____

**List any medications you are currently taking:**

_____

_____

_____

_____

_____

Pre-medication required _____

Consulting Physician _____

Pharmacy_____

**Check if you have had any problems with the following:**

- ☐ Bad breath
- ☐ Bleeding, sensitive gums
- ☐ Clicking or popping jaw: right or left
- ☐ Food trapped between teeth
- ☐ Grinding or clenching teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to hot or cold
- ☐ Sensitivity to sweets or biting
- ☐ Sores in or around mouth
- ☐ Staining teeth

**Please check any services below that you would like for our staff to discuss with you during your visit:**

- ☐ Crown / Bridge / Veneers (Lumineers)
- ☐ Partials / Dentures (Custom Made)
- ☐ Implants (Replace Missing Teeth)
- ☐ Invisalign (Invisible Braces)
- ☐ Night / Sports Guards (Clinch/Grind Protection)
- ☐ Sealants (Protect Your Teeth from Cavities)
- ☐ Silver (Amalgam) Filling Replacement
- ☐ Teeth Whitening (ZOOM!2 or Custom Trays)

**Reviewed by**: _____

## FINANCIAL AND CANCELLATION POLICIES

- We accept Cash, Checks, Debit Cards, Visa, Master Card, American Express, Discover, and CareCredit.
  - Financing may be available – ask the front desk for more details.
  - Prompt Payment Discounts are available in some cases for cash payments (paper currency or check not credit or debit card)
- All services are to be paid for at time of treatment. Please discuss all payment arrangements with the office manager prior to any treatment performed.
  - For surgery or crown appointments:
    - a non-refundable 50% deposit will be required when the appointment is made

- In this age of diminishing dental benefits, we pledge to work with you to obtain the dentistry that you desire as if you have no insurance benefit. M**any of our patients do not have a dental plan. If you do, be careful not to let the "plan" choose your treatment path.** Dental insurance coverage is a contract between you and your insurance company. Therefore, you are still ultimately financially responsible for your dental services. Please be aware that if we have not received payment from your carrier within 45 days after services have been rendered, you will be responsible for payment in full.
  - If we are not providers of your insurance, as a courtesy, we will be happy to submit claim forms to your insurance carrier and payment will be made directly to you from your insurance provider.
  - The patient is responsible for payment, in full, regardless of dental insurance coverage, divorce, or any other financial arrangements made between the patient and others.
  - It is your responsibility to present any insurance information PRIOR to treatment. We will not retroactively bill any services.
- A $10 charge will be added to all invoices sent after 30 days to cover administrative costs. If a balance exists, we will try to notify you a minimum of three times. Your signature below states that if you are aware that if you do not respond to these attempts to collect a balance, we may report you as delinquent to credit agencies.

POLICY FOR BROKEN AND/OR CANCELLED APPOINTMENTS

**Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you alone.**

We hope you will make every effort to keep your appointments. Kindly give 48 business hours notice for appointments to avoid loss of deposit. Since we never "double book", cancellations & broken appointments represent a loss in treatment time for you & also for other patients who would desire that time. It must be understood that once you miss an appointment, we will require a deposit for all future appointments. If you have any questions please do not hesitate to ask. Thank you for understanding our policies.

Your signature also states that you have read the above stated policies, have had the opportunity to have all your questions addressed, and agree to the terms listed above.

| SIGNATURE-PATIENT/GUARDIAN | DATE |
|---|---|
| WITNESS SIGNATURE | 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 March 24, 2014, 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 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 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.

**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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail, text, or email messages, postcards, or letters.)

## 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. You may also request access by sending us a letter to the address at the end of this Notice.)

**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 March 24, 2014. 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.

**RESTRICTIONS:** 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 of 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.

Contact Officer: Loren P.
Phone: 386-761-5883
Fax: 386-761-0993
Email: loren@smiledaytona.com
Address: 2644 South Ridgewood Ave, South Daytona, FL 32119

**HIPAA PATIENT CONSENT FORM**

**Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

The Notice contains a Patient's Right section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our web site. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

**The Patient understands that:**

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

Signature: _____ Date: _____

# GENERAL DENTISTRY INFORMED CONSENT

**Examination & X-Rays**

I understand that the initial visit will require radiographs in order to complete the examination, diagnosis, and treatment plan.

**Drugs, Medication, & Sedation**

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

**Changes in Treatment Plan**

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

**Temporomandibular Joint Dysfunctions (TMJ)**

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

**Fillings**

I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

**Removal of Teeth (Extraction)**

I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

**Crowns, Bridges, Veneers, & Bonding**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

**Dentures - Complete or Partial**

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

**Endontontic Treatment (Root Canal)**

I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

**Periodontal Treatment**

I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

**PLEASE CHECK BELOW**

□ I understand that every reasonable effort will be made to ensure that my condition is treated properly, although it's not possible to guarantee perfect results. By signing below, I acknowledge that I have received adequate information about the proposed treatment, that I understand this information and that all of my questions have been answered to my satisfaction.

□ No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

I attest that I have discussed the risks, benefits, consequences, and alternatives to this/these treatment(s) with the patient who had the opportunity to ask questions, and I believe my patient understands what has been explained.

_____ _____

Patient Signature Date