

Welcome

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ SS # _____
Date _____

Address _____
City _____ State _____ Zip _____

Email Address _____

Birthdate _____ Home Phone # _____ Work Phone # _____

Do you prefer to receive calls at: Home Work Either Cell Phone # _____

Are you: Minor Married Divorced Widowed Single Separated

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parents name _____ Workplace _____ Work Phone # _____

If you are a student, name the school/college _____ City _____ State _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone # _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? NO YES IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Eaglesoft Medical History(Copy)(Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Yes No If yes _____

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

Have you ever had a serious head or neck injury? Yes No If yes _____

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

Have you been told you snore? Yes No

Have you been diagnosed with Sleep Apnea? Yes No If yes _____

Do you wear a C-PAP? or Have you in the past? Have you been told to? Yes No If yes _____

Have you had a sleep study or been told to get a sleep study? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes _____

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No
Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No	Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No
Stroke <input type="radio"/> Yes <input type="radio"/> No	Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No	Chest Pains <input type="radio"/> Yes <input type="radio"/> No
Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No
Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No
Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed above? Yes No If yes _____

Comments:

Additional Questions

Do you suffer from the following:

Acid Reflux/GERD Depression

Fibromyalgia Periodontal Disease

Insomnia Trouble Sleeping

Sleep Apnea wake up frequently

Morning Headaches Frequent urination at night

Restless Leg Anxiety

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

Financial Policy

Your Health is our first and foremost Priority. Dental care will always be rendered based on need and no other factor will affect the quality of that care.

BY BOOKING AN APPOINTMENT YOU ACKNOWLEDGE THAT YOU HAVE READ & AGREE TO ALL OF OUR POLICIES AND PROCEDURES.

This is an agreement between Sara K Dean as a creditor and the patient/debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

MONTHLY STATEMENT: All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.

INSURANCE: Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider. We accept most PPO insurances. If there is dental insurance on the account, I understand that the practice has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

We **do not** accept any **HMO** plans, and we do not accept Medicaid/Medicare plans.

Note : If your insurance changes, please provide the new information 72 hours prior to your dental appointment.

Financial Responsibilities: As a patient of Sara Kohen Dean, you understand that you are responsible to pay in full at the time any service is rendered. We accept most major credit or debit cards: **MASTER CARD, DISCOVER, VISA, CASH or CHECK and Care Credit.**

A **\$35.00 return** service fee will be charged for any check that is returned for insufficient funds.

CANCELATIONS: We require clients to provide us with at least 48 hours' notice (within business hours) if you are unable to keep the time, we have reserved for your 1 hour or less in length appointment any cancellation/no-show or rescheduling less than 48 hours prior to your appointment will result in a cancellation fee of \$50.00.

FOR APPOINTMENTS TWO HOURS OR LONGER IN LENGTH, THE GREATER OF \$250.00 OR 50% OF THE FEE ESTIMATED IS PLACED AS A DEPOSIT ON THE RESERVED TIME.

The deposit will be applied towards the upcoming treatment's fee. If insurance is a primary form of payment and expected to pay more than the deposit, a credit will be issued the day of your procedure. A two-business day notice is required in circumstances of rescheduling (due to closure, Friday, Saturday, and Sunday are not business days). If insufficient notice is not provided or other priorities arise so that you prefer to forfeit the deposit, the deposit is applied to the fixed cost of practice operations and an additional deposit will be reserved for the next appointment.

PATIENTS'S FAILURE TO KEEP APPOINTMENTS

IMPORTANT

We have more patients who need dental care than we often have room in our daily schedule to provide. It is the inevitable result of the fact that we care about our patients dearly and prove it every day. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who desperately needs dental care. This policy is our attempt to ensure that both you and other patients receive the dental care that is needed.

After 3 consecutively missed appointments, cancelations/reschedules the patient will be dismissed from the practice.

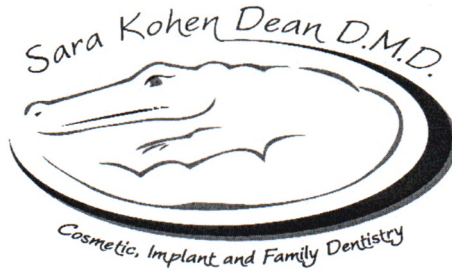
If you are more than 15 minutes late for your service, we may not be able to accommodate you. In this case, the cancellation fee will apply.

PATIENT RECORDS: Florida law requires that we keep your dental records for a period of 7 years. We will gladly send a copy of your records to another doctor free of charge should you relocate or wish to change dentist for any reason. All you need to do is fill out a release form that authorizes us to send your records elsewhere and provide us 48 hours to process the request.

Patient's name: _____

Patient or parent/Guardian Signature: _____

Date: _____



SLEEP QUESTIONNAIRE

Patient's name: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

- Sitting and reading _____
- Watching TV _____
- Sitting inactive in a public place (theater) _____
- As a passenger in a car for 1 hour _____
- Lying down to rest in the afternoon _____
- Sitting and talking to someone _____
- Sitting quietly after lunch without alcohol _____
- In a car stopped in traffic for a few minutes _____

No chance of dozing = 0
 Slight chance of dozing = 1
 Moderate chance of dozing = 2
 High chance of dozing = 3

Do you SNORE loudly? Yes/No

Do you often feel TIRED, fatigued, sleepy during daytime? Yes/No

Has anyone OBSERVED you stop breathing during sleep? Yes/No

Do you have or are you being treated for high blood PRESSURE? Yes/No

Have you ever had a sleep study? Yes/No

Have you ever had surgery for snoring or sleep apnea? Yes/No

Have you tried CPAP Yes/No

- If yes, how many nights do you wear it? _____
- How many hours a night do you wear it? _____

Please comment about any other snoring or sleep quality concerns:

Patient Signature: _____

Date: _____

Confidentiality List / (Patient Access Request)

OFFICE NAME

Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524.

"The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice."

Patient Name			
Date of Birth		<input type="checkbox"/>	Patient is a Minor

Notice: Requesting Medical Records (PHI) From Our Office

Our office requires patients and their representatives to sign this Access Form directing release of PHI to other individuals.

OPTION 1: ALL RECORDS WILL BE DISCLOSED

Please list all family members or other person(s), if any, whom we may disclose your protected health information, including treatment and payment information. These people will have full access to your protected health information and are able to request copies of your medical records (PHI) and may also have full online portal access to your records.

<u>NAME</u>	<u>PHONE NUMBER</u>	<u>RELATIONSHIP</u>

OPTION 2: LIMITED RECORDS WILL BE DISCLOSED

Please list all family members or other person(s), if any, whom we may disclose your protected health information, including treatment and payment information. These persons will NOT have full access to your PHI. Sexual Health Information allowed to be withheld by state law must be withheld as well as Mental Health and Drug Use protected by Disclosure of Substance Use Disorder Patient Records: Title 42 of the Code of Federal Regulations (CFR). These people will have the ability to request medical records (PHI), but will not be given access to the patient portal as our office is unable to segment records in the portal.

<u>NAME</u>	<u>PHONE NUMBER</u>	<u>RELATIONSHIP</u>

OPTION 3: Do Not Discuss My Personal Health Information with Anyone Other Than Myself.

Your information will be kept Confidential Under HIPAA Guidelines except Health care providers may disclose the necessary protected health information to anyone who is in a position to prevent or lessen a threatened harm, including family, friends, caregivers, and law enforcement, without a patient's permission.

<input type="checkbox"/>	Signed:	
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- I hereby consent for the practice to disclose protected health information (PHI) about me to the person or persons listed above in the manner described. This release of PHI is in addition to releases disclosed in our Notice of Privacy Practices.
- I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. Patients must notify our office of any changes; this form does not have an expiration date.

I have read and agree to all of the above.

Patient/Guardian Signature:							
Printed Name:		Date:					
Personal Representative Relationship							
If other than the patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient for payment or treatment?			<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>						

HIPAA CONSENT FOR ELECTRONIC BREACH NOTIFICATION

This consent form relates to your agreement to receive notification of any potential or confirmed breaches of your Protected Health Information (PHI), as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), via unencrypted email instead of through regular postal mail.

CONSENT

I, _____ [Patient's Full Name], consent to receive unencrypted electronic notifications about any potential or actual breaches of my Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) from HealthProvider.

I understand that:

Purpose: The purpose of this consent is to allow HealthProvider to notify me via unencrypted email instead of regular mail in the event of a breach of my PHI.

Risks: Transmission of emails over the internet may not be secure and could be intercepted by third parties, potentially leading to unauthorized disclosure of my PHI.

Right to Revoke Consent: I have the right to revoke this consent at any time by providing written notice to HealthProvider. I understand that revocation will not affect any actions taken before the receipt of my written notice.

Duration: This consent will remain in effect until I revoke it in writing.

Alternative Communication: If I do not wish to receive breach notifications via email, I can choose to receive them via regular mail.

CONSENT ACKNOWLEDGEMENT

I hereby acknowledge that I have read and understood the above information. I voluntarily give my consent to HealthProvider to send notifications of any potential or confirmed breaches of my Protected

Health Information via unencrypted **email** to: _____

Electronic breach notification must be sent only via encrypted email.

Patient's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____