Palm Harbor Premier DENTAL

Welcome to our office! We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments or fees, please ask us.

PLEASE PRINT

DATE: _____ EMAIL ADDRESS: _____

PATIENT'S NAME: _____

MARITIAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

SPOUSE'S NAME: _____

ADDRESS: _____ _____ CITY: _____ STATE: ZIP: _____

PHONE: _____ | _____ | _____ | _____
Home Work Cell Preferred

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY # _____

EMPLOYED BY: _____

BUSINESS ADDRESS: _____

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO

NAME OF INSURANCE CO.: _____

POLICY HOLDER: _____ SOCIAL SECURITY # OF POLICY HOLDER: _____

DATE OF BIRTH OF POLICY HOLDER: _____

EMPLOYED BY: _____

BUSINESS ADDRESS: _____

IF PATIENT IS A CHILD, PARENT OR LEGAL GUARDIAN NAME: _____

PURPOSE OF VISIT: _____ FORMER DENTIST: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

IF REFERRED BY ANOTHER PATIENT, WHOM MAY WE THANK FOR REFERRING YOU? _____

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____ ADDRESS: _____

Palm Harbor Premier DENTAL

Dental History

1. Are you having any discomfort at this time? _____
2. What concerns you the most? _____
3. When was your last dental visit? _____
4. Do any of the following cause tooth discomfort?
   ☐ HOT ☐ COLD ☐ SWEETS ☐ CHEWING
5. Do you have any sores in or around your mouth? _____
6. Are you aware of any swelling or lumps in your mouth? _____
7. When was your last dental cleaning? _____
8. Do your gums bleed when you brush or floss? _____
9. Have you ever had periodontal (gum) treatments? _____
10. Is there any unpleasant taste or odor in your mouth? _____
11. Which of the following do you use at home on a regular basis?
    Toothbrush: ☐ Hard ☐ Medium ☐ Soft ☐ Electric
    ☐ Floss ☐ Mouthwash ☐ Gum massager ☐ Oral Irrigator (water pik)
    ☐ Fluoride (other than fluoridated toothpaste) ☐ Other cleaning device _____
    Have either of your parents lost any teeth due to gum disease? ☐ Mother ☐ Father ☐ Both
12. Do you have any missing teeth? ☐ Yes ☐ No
    Have they been replaced? ☐ Yes ☐ No
    Are you comfortable with the replacements? ☐ Yes ☐ No
13. Do you have any loose teeth? ☐ Yes ☐ No
14. Have you ever had orthodontic treatment (braces)? ☐ Yes ☐ No
15. Do you lose fillings or break fillings? ☐ Yes ☐ No
16. Do you eat much citrus fruit? ☐ Yes ☐ No
17. Do you frequently drink soft drinks? (regular/ diet) ☐ Yes ☐ No
18. Do you usually have many cavities? ☐ Yes ☐ No
    Cracked or broken teeth? ☐ Yes ☐ No
19. Do you have any noticeable wear on your teeth? ☐ Yes ☐ No
    Food traps? ☐ Yes ☐ No
20. Do you grind or clench your teeth? ☐ Yes ☐ No
21. Do you have frequent headaches? ☐ Yes ☐ No
22. Do you have frequent pain in or around your ears? ☐ Yes ☐ No
23. Does your jaw hurt when you open your mouth wide, yawn or chew? ☐ Yes ☐ No
24. Do you notice any clicking or grinding noises in your jaw joint? ☐ Yes ☐ No
25. Does your jaw get "stuck," "locked" or "go out?" ☐ Yes ☐ No
26. Does your bite feel uncomfortable or unusual? ☐ Yes ☐ No
27. Have you had any injury to your jaw, head or neck? ☐ Yes ☐ No
28. Have you ever been treated for a temporomandibular disorder? ☐ Yes ☐ No
    If so, when, what, how and by whom?

    _____
29. Do you like the appearance of your teeth and your smile? ☐ Yes ☐ No
    If not, what would you like to change the most in the appearance of your teeth?

    _____
30. Have you ever had an unpleasant dental experience or are dissatisfied with your past dentistry?

    _____
31. Please add anything else you feel is important.

    _____

    _____

    _____

Medical History

Patient's Name: _____ Date of Birth:_____

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes, please explain:_____
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes, please explain:_____
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes, please explain:_____
Are you taking any medications, pills or drugs?	○ Yes ○ No	If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes, please explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes, please explain:_____
Are you on a special diet?	○ Yes ○ No	If yes, please explain:_____
Do you use tobacco?	○ Yes ○ No	If yes, please explain:_____
Do you use controlled substances?	○ Yes ○ No	If yes, please explain:_____

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex
☐ Sulfa Drugs ☐ Other If yes, please explain: _____

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

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

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

Comments: _____

_____

_____

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: _____ Date: _____

Financial Policy

As a courtesy to our patients, our office is happy to file your dental insurance for you and wait up to **30 days** for payment from them. If you prefer, we will collect the full amount due directly from you at the time of service and bill the insurance company for payment to go directly to you.

If you choose to have us wait for your insurance payment, we will collect the amount we **estimate** will be due from you at the time of service. Though we strive to be accurate, this is only an **estimate** and a balance may be due after the insurance has paid their portion.

After **30 days** or upon payment from your insurance company, the balance becomes due and payable in full by you. If a problem arises with the claim, we will continue to do whatever is necessary to see that you are reimbursed any amount still due to you by your insurance company.

Failure to pay your balance may result in a late fee of $50.00.

Returned check fee $40.00.

I have read the agreement above and understand the terms. I choose to have the payment paid directly to the provider of service.

Signature

I choose to pay the full amount due at the time of service and have the insurance payment come directly to me/I don't have dental insurance.

Signature

Notice of Privacy Practices of Palm Harbor Premier Dental

The law requires us to maintain your privacy, to give you this notice and to follow the terms of this notice. This notice describes how your health information may be used, disclosed and how you can access this information. Please review it carefully.

The law permits us to disclose your health information to those involved in your treatment. For example, a review of your file by a specialist whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, if you have insurance, we may send a report of your progress to your insurance company. We may also share information with our business associates, such as a billing service. We will have a written contract with each business associate that requires them to protect your privacy. All records containing health or personal information will be shredded if no longer needed and all such retained information will be kept secure.

We may use or disclose your information to contact you. For example, we may send you newsletter or other information. We will also call to confirm the time and day we have reserved for your dental care. If you are not home, we may leave this information on your answering machine or with the person who answers the phone. We may need to contact you from time to time. We will use whatever address and telephone number you prefer.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. We will need a signed request for the transfer. A reasonable fee may apply.

You have the right to see and receive a copy of your health information, with a few exceptions, in a timely manner without delays for legal review. Please give us a written request regarding the information you would like to see. If you also would like a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Please give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

Acknowledgement

I have received a copy of the Privacy Practices Notice of Palm Harbor Premier Dental

Signed _____ Print Name ____ _____

If signing as a parent or guardian, please note the name o f the patient. _____

Cancellation Policy

Palm Harbor Premier Dental has a policy of 24 hours for appointment cancellations and/or rescheduling. If an appointment is not cancelled or rescheduled within the 24 hours, then a fee of $50 per appointment is applied for services scheduled on weekdays (Monday-Friday.)

We understand emergencies are unavoidable and will be assessed on a case-by-case basis. As your dental provider, it is our commitment to provide you with high quality service and professionalism. While we regret to implement this fee, it is standard for most health facilities and has become a necessity for us to run an efficient dental practice. We value your patronage and look forward to being your dental provider for years to come.

Respectfully,
Palm Harbor Premier Dental

Signature_____ Date_____

Print Name_____

30685 US Highway 19 N., Palm Harbor, FL 34684 ○ (727) 249-0460 ○ info@palmharbordental.com

Authorization for Release of Information

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize *Palm Harbor Premier Dental* to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____Phone number_____

2._____ Relation to Patient:_____Phone number_____

3._____ Relation to Patient:_____Phone number_____

Authorization to Leave Detailed Messages

Occasionally it is necessary for the staff of *Palm Harbor Premier Dental* to leave messages for patients. The purpose of these messages are to notify the patient that we would like to discuss treatment needs, billing purposes or to ask a patient to call back regarding an issue or concern. To expedite the receipt of the needed information, please indicate below if you would like to give consent to leave detailed messages.

Please mark your preference below:

_____ I authorize *Palm Harbor Premier Dental* to leave detailed voicemails.

This is the phone # I would like messages left: _____

_____ I authorize *Palm Harbor Premier Dental* to send detailed emails.

This is the email address I would like messages sent: _____

_____ I do not want any detailed messages left on voicemail or sent via email.

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above authorized recipient or voicemail or email is no longer protected by federal or state law and may be subject to redisclosure by the above recipient or someone who has access to your voicemail or email.

You have the right to revoke this consent in writing.

Signature:_____Date:_____