Carrollwood Smiles

3401 W. Fletcher Ave., Suite A • Tampa, FL 33618 • (813) 269-4000

PATIENT REGISTRATION

Patient Number **A B C** Today's Date

Patient's Name Sex: M F Birthdate Age

Home Address City State Zip

Please Circle One: Single Married Separated Widow Your Soc. Sec. #

Home Ph.# Cell Ph. # E-mail Address

Your Employer Work Ph. # How Long Employed

Are you a full time student? ☐ Yes ☐ No *If patient is minor we need:* *Mother's DOB* *Father's DOB*

Person responsible for account Driver's License # Relationship

Name of spouse (parent if minor) Spouse's (parent's) Soc. Sec. #

Spouse's (parent's) Employer Work Ph. # Cell Ph. #

EMERGENCY INFORMATION
Name, address, & telephone of a relative not living with you

Reason for this visit

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)		**If you have double digit insurance coverage, complete this for the 2nd coverage**	
Insured's name		Insured's name	
Insured's employer		Insured's employer	
Insurance Co		Insurance Co	
Insurance Co Address		Insurance Co Address	
Phone #	DOB	Phone #	DOB
SS#		SS#	
Group #	Local #	Group #	Local #

Patient Financial Agreement

Carrollwood Smiles requires all patients to make financial arrangements with us before providing treatment. In order to receive treatment from us, you are making the following representations to us, which you affirm that you have read, understood and agreed to:

• I understand that full payment is due at time of service including emergency visits for myself of any of my dependents, or at the initiation of service under a treatment plan that I or any of my dependents have requested. My payment options are cash, check, and major credit cards. Further, if I qualify based solely on my credit history and income, a financing program may be available through a financial institution that Carrollwood Smiles has a relationship with. I understand that Carrollwood Smiles has no obligation to provide or procure financing for the services they render on behalf of myself or my dependents.

• In the event that Carrollwood Smiles is able to certify that I or any dependents have insurance coverage from information that I provided, I understand that I will be required to pay in full the portion of Carrollwood Smiles billing for any procedures or treatment plan requested for myself or my dependents that Carrollwood Smiles estimates will not be covered by my insurance prior to such treatment being performed by Carrollwood Smiles. I understand that this estimate of insurance by Carrollwood Smiles may differ from the payments ultimately made by my insurance carrier and that I am responsible for any amounts not paid by my insurance for any reason.

• With respect to any dental insurance I may have, I understand that my insurance benefits are derived from a contract between either myself and my employer and the insurance carrier, I also understand the extent of my insurance coverage depends on the quality of the plan that I or my employer has purchased.

X _____

- I realize that it is my sole responsibility and not the responsibility of Carrollwood Smiles, to confirm which treatments or procedures are covered by my insurance, the extent of this coverage including any applicable exclusions, deductibles, or annual or lifetime maximums in my insurance carriers usual and customary fee schedule.

- I understand that all insurance claims form treatment that I receive at Carrollwood Smiles are being filed by Carrollwood Smiles with my authorization as a courtesy to me and are subject to review by my insurance carrier. I understand that Carrollwood Smiles will submit a claim with my insurance carrier up to 2 times per appointment and that any further insurance appeal is my responsibility. I also acknowledge that I am solely and ultimately responsible for paying all charges not covered by my insurance for any reason, policy deductibles, policy annual maximum, or lifetime benefits exceeded, my insurance carrier paying an amount for a procedure based on its usual and customary benefit schedule which is less than the fees charged by Carrollwood Smiles for such a procedure and Carrollwood Smiles not receiving payment within 60 days of the procedure performed even If I am appealing the denial of insurance benefits by my carrier.

- I understand that If I opt to discontinue treatment for a procedure requested by Carrollwood Smiles to be perform, including partials, dentures, crowns, bridgework, surgical prepatory work, implant parts, bone graft and guided tissue membrane, I will be responsible for paying all lab costs for materials and services that such costs will be deducted from any refund that I may be entitled to as result of any pre-payments for the requested services.

- I understand that any and all account balances over 30 days old will incur an monthly interest rate charge at the maximum legal rate allowed.

- I understand that I have the right to dispute charges on my account and agree in good faith in resolving such dispute charges with Carrollwood Smiles. To the extent that I am unable to resolve such matters directly with Carrollwood Smiles, I agree to pursue resolution through an informal mediation process with a mutually agreed independent third party rather than through civil litigation.

- I understand that if a check, or other instrument, or any electronic authorization or debit send or provided to Carrollwood Smiles for payment Is not honored upon first presentment, regardless of the reason, even if the check, instrument, or electronic authorization is later honored, I will be charged a service charge. The charge is currently $25.00 and is subject to change without notice.

- I understand that if my account is not paid on timely basis, Carrollwood Smiles may report such untimely payment to credit ratings bureaus, refer my account to collection agency and to take legal action against me in order to receive full payment for services performed on myself or any dependents. I agree to pay related reasonable attorney's fees, collection, and/or current costs, a monthly interest charge on my outstanding account at the maximum rate permitted by law.

- I understand that the charge for copies of X-rays and treatment information is currently $25.00 and is subject to change without notice.

- I understand that Carrollwood Smiles reserves the right to charge any fee for any appointment that I do not keep currently at a rate of $30.00 and is subject to change without notice. After two broken or missed appointments, the dentist retains the right to discontinue elective treatment and to dismiss me from the practice.

Signature of Patient:_____

Signature of Parent/Guardian: _____

DENTAL HISTORY

Please check any of the following problems that apply to you.

	Yes	No
-Sensitivity (hot; cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you have or have you had any of the following?		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Periodontal (gum) treatments	☐	☐

Please share the following dates:

- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Name of Previous Dentist _____

City _____ State _____

Phone Number _____

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐
How much?_____ For how long? _____		
If I could change my smile, I would:		
-Make it whiter	☐	☐
-Make it straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Scarlet Fever	☐	☐
Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	HPV (Human Papilloma Virus)	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
Angina (Chest pain)	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Sleep Apnea	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Stomach Problems	☐	☐
Artificial Heart Valve	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Blood Disease	☐	☐	Heart Lesions (Congenital)	☐	☐	Nervousness/Depression	☐	☐	Ulcers	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Venereal Diseases	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Pregnant Currently	☐	☐	Other _____		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Radiation (head/neck)	☐	☐	_____		
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Respiratory Problems	☐	☐	_____		
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Rheumatic Fever	☐	☐	_____		
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐			

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Percodan	☐	☐	Tetracycline	☐	☐	Valium	☐	☐
Darvon	☐	☐	Latex	☐	☐	Codeine	☐	☐	Penicillin	☐	☐
Nitrous Oxide	☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐

Other _____

_____

_____

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosamax	☐	☐	Herbal Supplements	☐	☐
Reclast	☐	☐			

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

Family Physician Phone Number

_____

Consent:

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

Patient Signature (Parent if child) **Date** **Dentist Signature**

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 November 9th, 2011, and will remain in effect until we replace it.

We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices. The revised Notice will apply to all of your health information. We may also revise this notice from time to time. If we make any material revisions to this Notice, we will provide you with a copy of the revised Notice which will specify the date on which such revised Notice becomes effective. We are required to abide by the terms of the Notice that is currently in effect. 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

A. Use and Disclosure for Treatment, Payment, and Health Care Operations

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We also use and disclose health information about you for treatment, payment, and health care operations. For example:

- **Treatment:** We may disclose your health information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Health care Operations:** We may use and disclose your health information in connection with our health care operations, including quality assessment and improvement activities, review of the competence or qualifications of health care professionals, evaluation of practitioner and provider performance, training programs, accreditation, certification, and licensing and credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care 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.

Disclosures To Your Family and Friends: We may disclose your health information to a family member, friend, or other person identified by you to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Disclosures To Persons Involved in Your Care: We may also 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, 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 use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, and we will disclose only health information that is directly relevant to the person's involvement in your health care. 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, postcards, letters, e-mails, texts or other similar mobile device communications).

Patient-Related Communications: We may use or disclose your health information to provide patient-related communications such as intraoral photography, "no cavity club" for children, and telephoned-in prescriptions.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

B. Use and Disclosure for the Public Need

In particular situations involving the public need, we may disclose your health information without obtaining your authorization. Those situations include the following circumstances:

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

Public Health Activities: We may disclose your health information to authorized public health officials so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury, or disability.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections, as well as civil, administrative or criminal investigations, proceedings, or actions.

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.

Product Monitoring, Repair and Recall: We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

Law Enforcement: We may disclose your health information to law enforcement officials for certain reasons including to comply with court orders or laws that we are required to follow, and to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person.

To Avert a Serious and Imminent Threat to Health or Safety. 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. In such cases, we will only share your information with someone able to help prevent the threat.

National Security: We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may also disclose to military authorities the health information of Armed Forces personnel under certain circumstances. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

C. Partially De-Identified Health Information

We may use and disclose "partially de-identified" health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. If we maintain your health information in electronic format, you may request a copy of your information in electronic format and we will charge you no more than our cost of preparing the materials. If we maintain your information in paper files, you may request photocopies or copies in another format. We will use the format you request unless we cannot practically and reasonably do so. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. 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.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years or such shorter time as you may specify. That accounting would not include disclosures made for the purposes of treatment, payment, or health care operations, unless we maintain your health record electronically, in which case, after January 1, 2011, we may need to provide you with an accounting of treatment, payment, or health care operations disclosures for no more than 3 prior years, but not including any treatment, payment, or health care operations disclosures prior to January 1, 2011. 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. If we agree to your request, we will abide by our agreement except in an emergency situation. However, we are not required to agree to these additional restrictions, except that we must agree to a request that we restrict disclosure of your information to a health plan for purposes of payment or health care operations if the information pertains solely to a health care item or service that you have paid for out of pocket and in full.

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 a satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment of Health Information: 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.

Notification of Breach of Unsecured Health Information: Our policy is to encrypt our electronic files containing your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a breach of your unencrypted health information, we will notify you of the breach.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you have the right to request a paper copy of this Notice. You may make such a request by writing to the address provided at the end of this Notice.

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.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship

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)

_____

_____

_____