# PATIENT INFORMATION

Date: _____

Name: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. _____

☐ Child ☐ Single ☐ Married ☐ Widowed ☐ Divorced Age ____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Business Phone _____ Ext _____ Email _____

Social Security# _____ Drivers License No. _____

Employer _____ Occupation _____

Dental Insurance ☐ Yes ☐ No If Yes, Insurance Name _____ Group # _____

Insured Person's Full Name _____ DOB _____ SS# _____

Relationship to Patient _____ Employer's Name _____

Responsible Party Name _____ DOB _____ SS# _____

Has any member of your family been treated in our office? Yes No

Whom may we thank for referring you to our office? _____

Call in Case of Emergency _____ Relationship _____ Phone _____

Reason for Visit _____ Best time to call _____ Alternate _____

# MEDICAL HEALTH

Name and Address of Physician _____

Physician's Phone # _____ Last Complete Physical? _____

Please Check Those Conditions That Now or Have Ever Pertained To You

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Are you currently under the care of a physician? | ☐ | ☐ | Convulsions or Epilepsy |
| ☐ | ☐ | Heart Murmur or Congenital Heart Defect | ☐ | ☐ | Bleeding Problems |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Lung Problems or Tuberculosis |
| ☐ | ☐ | Open Heart Surgery | ☐ | ☐ | AIDS/HIV |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Dizziness or Fainting Spells | ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Kidney Disease | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Jaundice or Liver Disease | ☐ | ☐ | Arthritis |
| ☐ | ☐ | Cancer | ☐ | ☐ | Blood Disease(ie. Anemia) |
| ☐ | ☐ | Hepatitis | ☐ | ☐ | Sinus Trouble |
| ☐ | ☐ | Asthma | ☐ | ☐ | Stomach, Intestinal Trouble |
| ☐ | ☐ | X-Ray Therapy | ☐ | ☐ | Circulatory Problems |
| ☐ | ☐ | Pneumonia | ☐ | ☐ | Eye, Ear, Nose, Throat Trouble |
| ☐ | ☐ | Joint Replacement/Synthetic Implant | ☐ | ☐ | Females Only: Are you pregnant? |
| ☐ | ☐ | Bisphosphonates(ie. Fosamax, Actonel, Aredia, Reclast, or Boniva) | ☐ | ☐ | Are you Hearing Impaired? |
| ☐ | ☐ | Heart Disease or Heart Surgery | ☐ | ☐ | Excessive Fatigue |
| ☐ | ☐ | Stroke | ☐ | ☐ | Severe Headaches/Migraines |
| ☐ | ☐ | Abnormally High/Low Blood Pressure | ☐ | ☐ | Morning Headaches |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Do you Snore? |
| ☐ | ☐ | Depression | ☐ | ☐ | Do you Smoke? |

Are you Allergic or Sensitive to:

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Penicillin |
| ☐ | ☐ | Aspirin |
| ☐ | ☐ | Codeine |
| ☐ | ☐ | Demerol |
| ☐ | ☐ | Local Anesthesia like Novocaine |
| ☐ | ☐ | Latex |
| ☐ | ☐ | Other Drugs, Medicines, or food(list) |

_____

Are you presently taking Medications?

| Yes | No |
|---|---|
| ☐ | ☐ |

(if yes please list and give reason for taking)

_____

_____

_____

_____

EPWORTH SLEEPINESS SCALE: How likely are you to doze or fall asleep in the following situations?

0 = NO CHANCE OF DOZING 1 = SLIGHT CHANCE OF DOZING 2 = MODERATE C.O.D. 3 = HIGH C.O.D.

_____ Sitting and Reading
_____ Watching TV
_____ Sitting Inactive in a Public Place(i.e. Theater, Meeting)
_____ As a passenger in a Car for an hour without break
_____ Lying Down to Rest in the Afternoon When Circumstances Permit
_____ Sitting and Talking to Someone
_____ Sitting Quietly After a Lunch Without Alcohol
_____ In a Car, while stopped for a few minutes in traffic

# DENTAL HEALTH

Name and Address of Former Dentist: _____

When Was Your Last Visit? _____ What Was Done At That Time? _____

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Are your teeth sensitive to sweets? Temperatures? |
| ☐ | ☐ | Have you been under regular care by a dentist? |
| ☐ | ☐ | Do any of your teeth ache? |
| ☐ | ☐ | Do your gums feel tender or swollen? |
| ☐ | ☐ | Do you notice popping in your jaw? |
| ☐ | ☐ | Have you had any teeth removed? |
| ☐ | ☐ | Were there any complications involved afterwards? |
| ☐ | ☐ | Do you have any loose teeth? |
| ☐ | ☐ | Do your gums bleed or have pain? |
| ☐ | ☐ | Do you clench or grind your teeth? |
| ☐ | ☐ | Have you had orthodontic treatment? |
| ☐ | ☐ | Do you think you have active decay or gum disease? |
| ☐ | ☐ | Do you feel nervous about dental treatment? |
| ☐ | ☐ | Have you ever had a bad experience in a dental office? |
| ☐ | ☐ | Does food trap between your teeth? |
| ☐ | ☐ | Are you happy with the appearance of your smile? |
| _____ | | Rate your smile(1-10, with 10 being the highest) |
| ☐ | ☐ | Do you have spaces or gaps between your teeth? |
| ☐ | ☐ | Do you have old fillings or dental work you perceive to be unattractive |
| ☐ | ☐ | Are your teeth chipped, protruding, crowded or misshapen? |
| ☐ | ☐ | Do you feel you will eventually wear artificial dentures? |

How often do you brush? Floss? Mouthwash? _____

Why did you leave your last dentist? _____

What brought you to our office? _____

How do you feel we could help you? _____

# CONSENT FOR PROCEDURE

I certify that all the above medical and dental information is true to my knowledge and I have not omitted any patient information. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic and nitrous oxide as indicated. I understand that I will be informed of any treatment changes as they occur. I will assume responsibility for fees associated with all procedures and all costs incurred in the collection of those fees.

Patient (Parent's) Signature X _____ Date _____

If you wish to assign benefits available to you under your dental insurance policy, please sign:

X _____ Date _____

Doctor's Signature _____ Date _____

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 4/1/2015 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Jorge R. Angulo, DDS. Information on contacting us can be found at the end of this Notice.

**We will keep your health information confidential, using it only for the following purposes:**

**Treatment:** While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

**Disclosure:** We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

**Right to an Accounting of Disclosures**: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $2.00 for each page and the staff time charged will be $15.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

**Right to Request Restriction of PHI:** If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

**Required by Law**: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

**Fundraising:** We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

**Sale of PHI:** We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

**Appointment Reminders:** We may use your health records to remind you of recommended services, treatment or scheduled appointments.

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $2.00 for each page and the staff time charged will be $15.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Breach Notification Requirements:** It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

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**QUESTIONS AND COMPLAINTS**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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. **HOW TO CONTACT US:**

Practice Name: THORNTON PARK DENTAL ARTS Privacy Officer: JORGE ANGULO, D.D.S.

Telephone: 407-896-2881 Fax: 407-897-5389

Email: michele.tpda@gmail.com

Address: 1200 E. Robinson Street, Orlando FL 32801

# FINANCIAL AGREEMENT

It is our policy to have a definite agreement between you the patient, and this office concerning the payment of the fees for services rendered. Before treatment, you will be advised of the approximate cost. For convenience, we accept Debit, Cash, Check, Visa, MasterCard, American Express & Discover. All emergency dental services or any dental service performed without previous financial arrangements with the office manager must be paid for AT THE TIME OF SERVICE.

## Scheduled Appointment Policy

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that our patients make every effort to keep their reserved dental appointments. As a courtesy, our office will call in advance to confirm all patient appointments. Broken and missed appointments create scheduling problems for other patients as well as our practice. **If you find that you must change your appointment, we require a minimum of 24 hour notice so that we may accommodate another patient. Each missed or cancelled appointment, if less than a 24 hour notice is given, will result in a $50.00 fee.** After three consecutive missed appointments, we feel that your philosophy and our philosophy on the important of your treatment needs to not match and will result in a dismissal from our practice.

## Patients Not Covered by Dental Insurance

Payment in full is expected when services are rendered.

## Patients Covered by Dental Insurance

If you have dental insurance, we will be happy to complete the necessary forms for your claim as a courtesy to you. However, your insurance is a contract between you and your insurance company and you are responsible for your entire bill regardless what your insurance pays. We are only a third party providing the service to you. This office requires that you will be responsible for your co-payment and deductible at the time of service. After insurance has been filed and benefits have not been received within 60 days from your insurance company, the entire balance becomes patient responsibility. A refund will be given when the benefits have been received from the insurance company. This office cannot render services on the assumption your charges will be paid by your insurance company.

In consideration for the professional service rendered to me, by the Doctor, I agree to pay for those services in full. In the event that my account becomes delinquent, I understand that my account will be turned over to collections. Additionally, I agree to pay any court costs and attorney fees, which may be associated with my account. I grant my permission for you to telephone me at home or work to discuss matters related to this form.

**I have read and understand the above financial and office policy agreement.**

Patient / Guardian Signature _____ Date _____

# FACTS REGARDING DENTAL INSURANCE

**Dental insurance is rapidly playing a larger role in helping people obtain dental treatment. Since we strongly feel our patients deserve the best possible dental care we can provide, and in an effort to maintain this high quality care, we would like to share some facts about dental insurance with you.**

**FACT #1: Dental insurance is not meant to be a PAY-ALL. It is only meant to be an aid.**

**FACT #2: Many Plans tell their insured that they'll be covered "up to 80% or up to 100%". In spite of what you're told, we've found most plans cover less than the average fee. Some plans pay more - some less.**

**FACT #3: It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying to them that "our benefits are low".**

**FACT #4: Many ROUTINE dental services are not covered by insurance plans.**

**Please do not be hesitant in asking us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. We will fill out and file insurance forms at no charge. We will do all we can to assure you of maximum benefits.**

**IF WE TAKE ASSIGNMENT ON YOUR INSURANCE, WE FEEL THAT 60 DAYS IS A REASONABLE LENGTH OF TIME FOR US TO WAIT FOR PAYMENT FROM YOUR INSURANCE COMPANY.**

**PATIENT SIGNATURE:_____**

# CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Patient' s Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

**Notice to Patient:**
By signing this form, you grant us consent to disclose your protected health care information to the individual(s) listed below. Our **Notice of Privacy Practices** provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You are entitled to a copy of this **Consent Form** after you have signed it.

*(To Be Completed by Patient or Patient's Representative)*

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to disclose my health care information with the person or persons listed below.

_____

_____

_____

_____

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

FOR OFFICE USE ONLY:

Name of Practice _____

Privacy Officer's Signature or Practice Representative _____

Date _____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

*Please print your name here*

_____

*Signature*

_____

*Date*

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

*Employee signature* *Date*