PATIENT HISTORY

NAME: Last First Middle Initial

(Name of PARENT if minor or legal guardian)

MAILING ADDRESS: CITY STATE ZIP CODE

PHONE NUMBERS: HOME# WK#: Patient/or Parent/Guardian CELL#: Patient/or Parent

(S)___(M)___(D)___(W) __(O)_____

BIRTHDATE: BIRTHPLACE: MARITAL STATUS:

SOCIAL SECURITY #: Patient or PARENT/GUARDIAN DRIVER'S LIC #: Pt/Parent/Guardian

OCCUPATION: Patient/Parent or Guardian EMPLOYER: Patient/Parent or Guardian

EMERGENCY NAME AND CONTACT NUMBER: (*DIFFERENT FROM YOUR NUMBERS*)

GETTING TO KNOW YOU

How did you hear about us? _____

Names of family members/friends who are patients here:_____

Date of your last dental visit? _____

PAYMENT METHOD

CASH _____ PERSONAL CK _____ CREDIT/DEBIT CARD _____

(we accept American Express, Discover, Mastercard, Visa)

***** Our office files primary insurance as a courtesy to our patients. You are always responsible for your deductible and **ESTIMATED %** at each visit for services rendered. If you have a secondary insurance, you **would personally be responsible to file for reimbursement. You are responsible for any balance left unpaid by your insurance company.**

INSURANCE COMPANY NAME GROUP # 1-800#

FOR ALL PATIENTS

I hereby authorize the dentist to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the above patient. I additionally authorize the dentist to choose and employ such assistance as he /she deems necessary. I also understand that full explanation of the procedure(s) involved will be given by the dentist and/or members of his/her staff. I agree to pay for all such services rendered by this office.

X

Signature of Patient or Parent/Guardian Relationship Date:

MEDICAL HISTORY

Yes__No__ Are you having any dental problems at this time?
If yes, please explain_____

Yes__No__ Do your gums bleed at any time?

Yes__No__ Do you feel nervous about having dental treatment?

Yes__No__ Have you had a bad experience in a dental office?

Yes__No__ Have you been under the care of a medical Dr. at any time during the past Five years? If yes, please explain: _____

Yes__No__ Have you been a patient in a hospital at any time during the past five years? If yes, explain: _____

Yes__No__ Are you taking any medications at this time? If yes, please list:

_____

Yes__No__ Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes, nausea) LATEX, Penicillin, aspirin, codeine, or any drugs or medications?

Yes__No__ Have you ever had any excessive bleeding requiring treatment?

Please check any major medical problems you have been or are currently being treated for:

__ heart failure	__ shortness of breath	__ hepatitis A
__ heart disease/attack	__ emphysema	__ hepatitis B
__ angina pectoris (chest pain)	__ cough	__ hepatitis C
__ high blood pressure	__ tuberculosis	__ jaundice or liver disease
__ heart murmur	__ asthma	__ blood transfusion/ yr____
__ mitral valve prolapse (MVP)	__ hay fever	__ drug addiction
__ Rheumatic fever	__ sinus trouble	__ hemophilia
__ congenital heart lesions	__ allergies or hives	__ syphilis
__ Artificial heart valve	__ diabetes	__ gonorrhea
__ heart pacemaker	__ thyroid disease	__ cold sores or fever blisters
__ heart surgery	__ x-ray or cobalt treatment	
__ artificial joint (metal)	__ chemotherapy/cancer-leukemia	__ epilepsy or seizures
__ pins/rods (metal)	__ arthritis	__ fainting or dizzy spells
__ anemia	__ rheumatism	__ nervousness
__ stroke	__ cortisone medication	__ psychiatric treatment
__ kidney trouble/disease	__ pain in jaw joints (TMJ)	__ sickle cell disease
__ ulcers	__ HIV positive	__ bruise easily
__ tobacco use	__ AIDS	__ immune system disorders

**ARE YOU OR HAVE YOU EVER TAKEN THE CLASS OF DURGS KNOWN AS BISPHOSPHONATES..I.E. FOSAMAX, BONIVA OR ACTONEL ____YES___NO

PHYSICIAN'S NAME & PHONE #: _____

Yes__No__ Have you ever been diagnosed with cancer or tumor? If yes, explain:

_____

Yes__No__ Are you on a special diet?

Yes__No__ Do you ever wake up from sleep short of breath?

Yes__No__ Do you use more than 2 pillows to sleep?

Yes__No__ Are you pregnant? If yes, when is your due date? _____

Yes__No__ Are you taking birth control pills?

Yes__No__ Do you now or have you ever used recreational drugs?

Yes__No__ When you walk up stairs or more than short distances, do you ever have to stop Because of chest pain or shortness of breath or being tired?

Yes__No__ Do your ankles swell during the day?

Yes__No__ Have you lost or gained more than ten pounds during the past year?

METROWEST VILLAGE FAMILY DENTISTRY
2295 S. HIAWASSEE RD. SUITE 216
ORLANDO, FL 32835

OFFICE POLICY

As a courtesy to our patients, we do file insurance; however your **estimated** portion is due at time of service. If there is any remaining balance after insurance payment has been made, you will be responsible to pay this in full upon receipt of your statement. Should you have a dental plan that does not pay the Dentist, you are to pay in full at the time of treatment. As a courtesy, we will file your insurance to have them reimburse you. We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CASH and CHECKS. If a check is returned to us for NSF, we will not accept another check from that time on. You will be expected to immediately pay the balance in full, as well as the NSF charge of $37, by credit card or money order. There will also be an **additional collection charge applied to any account turned over to a collection agency due to non-payment.**

Starting two days prior to your scheduled appointment, we will call to confirm. If we are unable to speak with you at that time, we **do REQUIRE you return our calls to confirm your appointment**. If we do not hear back by the end of the day prior to your appointment time, we will cancel the appointment and offer it to another patient. Confirmed broken appointments will result in a $40 charge. There will be a $25 charge for appointments cancelled without a 24 hour notice. We do have voicemail where you can leave a message if it's after hours.

All quoted treatment plan fees will be honored for 6 months from the date first quoted.

All children under the age of 18 must be accompanied by an adult or legal guardian in order to receive treatment.

Please keep us updated on any changes in regards to address, phone numbers, insurances or medical updates. If you have a change in your insurance, please call our office at **least 48 hours prior to your appointment** with your new information. We need this time to verify your new benefits. Advance notice is very important due to many new plans in which we do not participate.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY

_____

PATIENT SIGNATURE (or parent/legal guardian) DATE

METROWEST VILLAGE FAMILY DENTISTRY
2295 S. Hiawassee Rd. Suite 216
Orlando, Fl 32835

ACKNOWLEDGING NOTIFICATION OF HIPPA PRIVACY ACT

I (_____) am acknowledging that the staff of
(Print name patient if adult OR parent/legal guardian)

Metrowest Village Family Dentistry has notified me that they honor the Government Hippa Privacy Act.

By signing this, I am giving permission for my insurance to be filed, for any of the Dentists of Metrowest Village Family Dentistry to refer me to and discuss with a specialist if deemed necessary. I am agreeing to allow the staff to leave a message t confirm my appointment with a family member or person answering my phone or on my voice mail.

I understand that Metrowest Village Family Dentistry will not sell my personal information with any other organization.

I understand that I have the right to refuse to sign this agreement; however, this would mean that I would have to pay in full for each visit and file my insurance fo Reimbursement. Dr. Heap would not be able to discuss my treatment with a specialist if necessary and would not be able to have an assistant. Without an assistant, it would be impossible for any of the Dentists to perform treatment on m

X_____
(Signature of adult patient OR Parent/Legal Guardian) Date:

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our notice of Privac Practices but acknowledgement could not be obtained due to:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other..please specify

What is the HIPAA Privacy Rule?

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. It is a federal law under which the Secretary of the U.S. Health and Human Services issued regulations that give patients protections over the privacy of their dental records.

The final privacy regulation took effect April 14, 2003. It balances strong privacy protections against efficiency and access to quality health care. Patients are guaranteed access to their dental records; given more control over how their protected health information is used and disclosed; and are allowed to file complaints if their medical privacy is breached. The privacy rule protects medical records and other personal health information maintained by certain dentists, physicians, hospitals, health plans, health insurers and health-care clearinghouses.

Under the privacy rule, this dental practice:

- Must get your specific authorization before we may use or disclose your protected information in non-routine circumstances, such as releasing information to an employer or for use in marketing activities.
- Will allow you to request an account of non-routine uses and disclosures of your health information.
- Will provide you with written notice of our privacy practices and your privacy rights. Patients will generally be asked to sign, or otherwise acknowledge receipt of, the privacy notice from direct treatment providers such as dentists.
- May communicate freely with you about treatment options and with other health-care providers involved in your care.
- Will allow you to access your personal dental records and request changes to correct any errors.

The privacy rule, established as part of the federal privacy act, enhances protections under existing Florida law. Our dental practice adheres to Florida laws ***and*** federal laws that protect your health information. Our policies apply to all patients in this dental practice, whether they are privately insured, uninsured or covered under public programs such as Medicare or Medicaid.

We care about your oral health and are here to help you. If you have questions about how the HIPAA privacy regulation relates to your dental care, please feel free to contact our office.

The Florida Dental Association is pleased to provide this information on the HIPAA Privacy Rule as a public service.

FDA
FLORIDA DENTAL ASSOCIATION

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 12/01/02, 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 a 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 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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 April 14, 2003. 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.

Restriction: 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 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.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____