Hunters Creek Dentistry

Today's Date _____

Patient's Name		Sex: M F	Birthdate		Age
Home Address	City		Zip	Circle One: Single Married Separated Widowed	
Home Ph #	Cell Ph #	Email Address			
Your Employer		Work Ph #		SS#	
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/guardian if minor)		Spouse's (parents) SS #			
Spouse's Employer	Work #		Cell Ph #		
EMERGENCY INFORMATION Name & telephone of a relative not living with you					
Reason for this visit					
How did you hear about our office?					

DENTAL INSURANCE INFORMATION (Primary Carrier)		DENTAL INSURANCE INFORMATION (Secondary Carrier)	
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 #

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that your read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, VISA and Discover. Outside financing is available upon request and approval.

Please check if you would like more information about financing options. □

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance you will be responsible for any collection and/or legal charges up to 35%.

- As a courtesy to you we will help you process all your insurance claims**. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated**. Your insurance company and your plan benefit ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- **All charges you incur are your responsibility regardless of your insurance coverage**. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, VISA, or Discover at the same time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to service your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge, and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Responsible Party - Please Print _____ Patient Signature (Parent/Guardian if minor) _____ Date _____

Patient's Name: _____

DENTAL HISTORY

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

	YES	NO
Sensitivity (hot, cold, sweet, pressure)	☐	☐
Where? ☐ Upper Right ☐ Lower Right ☐ Upper Left ☐ Lower Left		
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	☐	☐

	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 from 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

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?_____

_____

Please share the following dates:	Month	Year
Your last cleaning	_____ /	_____
Your last oral cancer screening	_____ /	_____
Your last complete X-Rays	_____ /	_____

Name of your previous dentist: _____

Phone Number: _____

Patient's Name: _____

MEDICAL HISTORY

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

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

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

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

Have you ever taken any of the following medications?

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

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

_____

_____

What medications are you currently taking?

_____

_____

Family Physician _____ Phone Number _____

Consent:

The undersigned hereby 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 needs. I also authorize the 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/Guardian if minor) Dentist Signature Date

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)_____

CANCELLATION/MISSED APPOINTMENT POLICY

When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We ask that if you must change an appointment, please give us at least ***48 BUSINESS HOURS*** notice. This courtesy makes it possible to give your reserved room to another patient who would like it. **A charge of $50 may be added to your account if you do not show up for your scheduled appointment or for repeated cancellations without a 48 hour notice. Repeated cancellations or missed appointments may result in loss of future appointment privileges as well.** We feel that our patient's time is valuable. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Our goal is to deliver exceptional care for you and your family in a timely manner, and we appreciate your cooperation by honoring your scheduled appointment times.

Please sign that you have read and understand the above guidelines.

I have read and understand the Cancellation/Missed Appointment Policy.

_____

Patient Signature

_____

Patient Name (Print)

_____

Parent or Guardian Signature

_____

Parent or Guardian Name (Print)

Hunters Creek Dentistry

14009 Egret Tower Dr., Orlando, FL 32837

(407) 251-5100

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.

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 must follow the privacy practices as described below. This Notice will take effect on and will remain in effect until it is amended or replaced by us.

It is our 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, Vanessa Gonzalez Sierra. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use your health information to provide you with our professional services. 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.

Disclosure: We may disclose and/or share your healthcare information 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.

(a) 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. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1 for each page and the staff time charged will be $15 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

(b) Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider’s refusal of an individual’s request not to disclose PHI in instances where “the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

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 or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

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, outside health or management reviewers 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.

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.

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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

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.) 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 $1 for each page and the staff time charged will be $15 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. 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 a fee and/or 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.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is 'breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

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.

Signature :

HOW TO CONTACT US

Practice Name: Hunters Creek Dentistry

Privacy Officer: Vanessa Gonzalez Sierra

Telephone : (407) 251-5100

Address: 14009 Egret Tower Dr., Orlando, FL 32837

Email: contact@hunterscreekdentistry.com