

Welcome to Our Office 1810 S. MacDill Ave., #3 - Tampa, FL 33629

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

PATIENT INFORMATION:	Date
Name	Cell Phone
Address	
City	State Zip Code
Sex Age Date of Birth	Marital Status
Social Security #	Email Address
Employed by	Occupation
Business Address	Phone
Contact Information in case of emergency	
How did you hear about us? Whom should w	e thank for referring you?
DENTAL HISTORY:	
Reason for today's visit?	
Date of last cleaning, x-rays and exam?	
Particular area of concern you would like us	to pay special attention to today?
Are you happy with:	Other?
The color of your teeth? Yes / No The shape of your teeth? Yes / No The size of your teeth? Yes / No	What do you like about your smile?
Please place a check in the box next	t to any problems you have had with the following:
Bleeding gums Loose or b	cction between teeth Sensitivity to hot or cold Sensitivity to sweets cal treatment Pressure when biting Sores/growths in or outside of the mouth

MEDICAL HISTORY: Primary care physician's name _______Date of last visit_____ List any serious illness or operation that you may have had. If yes, describe (Women) Are you pregnant? _____Nursing _____ Do you premedicate prior to your dental visit? If so, please list medication PLEASE CHECK BOXES IF YOU HAVE OR HAD ANY OF THE FOLLOWING: **High Blood Pressure Cortisone Treatments Shortness of Breath AIDS HIV Positive** Skin Rash **Persistent Cough** Anemia **Kidney Disease** Cough up blood Stroke **Rheumatoid Arthritis Liver Disease** Swelling of feet/ankles **Diabetes Artificial Heart Valve Mitral Valve Prolapse** Thyroid **Epilepsy Artificial Joints Nervous problems Tobacco Habit Fainting Asthma** Pacemaker **Tonsilitis** Glaucoma **Back problems Migraine Headaches Psychiatric Care** Tuberculosis **Blood disease Radiation Treatments** Ulcers **Heart Murmur** Cancer **Respiratory Disease** HPV **Heart Disease** Chemotherapy **Rheumatic Fever** Hemophilia **Chemical Dependency Scarlet Fever** Hepatitis **Circulatory Problems** Pharmacy Name/Number ___ Medications currently taking: ___ **ALLERGIES:** Check all that apply: **PENICILLIN ASPIRIN** CODEINE SLEEPING PILLS **CLINDAMYCIN BARBITURATES LOCAL ANESTHETICS LATEX** Do you smoke?_____ If yes, how often?_____ Do you use chewing tobacco?_____ If yes, how often?_____ The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date _____ Signature ____

DENTAL INSURANCE INFORMATION: Our office is "fee for service", which means we collect all fees at the time of service. However, if you do have dental insurance we want to help you receive your benefits. We can do that by collecting your insurance information, filing your claim electronically, and having the payment of your benefit sent directly to you. This is typically a fast process—you should hear from your insurance company within 2-3 weeks, although **we cannot guarantee what the reimbursement amount will be.** We suggest you file a **pre-treatment estimate** request for all major work if you desire to know your benefit amount in advance. Please provide complete insurance information if you would like us to file claims for you.

Insurance Company:	
Address:	
Phone Number:	
Group Number:	
I.D. # or S.S. #:	
Subscriber name:	
Relationship to patient:	
Subscriber Date of Birth:	
S.S. #:	
Subscriber employed by:	
AUTHORIZATION:	
I authorize my insurance company to pay me directly for all insurance benefits otherwise payable to the dentist for services rendered. I authorize the use of this signature on all insurance submissions.	
I authorize the dentist to release all information necessary to secure the payment of benefits.	
I understand that I am financially responsible for all services performed at time of treatment.	
SIGNATURE:	
DATE:	

HIPAA PATIENT CONSENT FORM

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of our practice

I have also been informed I may review this office's copy of Notice of Privacy Practices, which contains a more complete description of uses and disclosures of my protected health information, and my rights under HIPAA. I understand this office reserves the right to change the terms of this notice from time to time and I may view the most current copy of the terms.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care. (See next form)

I understand I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this day of	, 20
Print Patient Name	
Relationship to Patient: (self or guardian) _	
Signature	

HIPAA PATIENT AUTHORIZATION FORM

This authorization sets forth your right to use or disclose my protected health information as specified below for the purposes and parties as designated below.
Description of specific information authorized: (list if you have specific direction)
Description of the specific purposes for use and disclosure:
Names of Relatives, Close Friends, or Caregivers to whom your health information may be disclosed
I reserve the right to:
 Revoke this authorization in writing by submitting it to the attention of our office Inspect or copy the protected health information to be used or disclosed Refuse to sign this authorization knowing the office will not condition treatment or payment on my providing this authorization.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
This authorization is effective from day of 20
Print Patient Name
Relationship (if other than patient)
Signature