New Patient Form

Palm Ridge Dental

(352-391-9930)

Pt. Name_____________________________ Date of Birth__________________
Preferred Name ______________________
Patient Gender: M__ F __ Martial Status: M __ S __ W __ Other ___
Name of Spouse:__________________ Spouse Date of Birth: ___________________
Pt. S.S. # ________________________ {Needed for insurance purposes}
Insurance ID # ___________________ Group # ____________________________ Home Address: ______________________ City: __________________State___ Zip____ Home Phone #: ___________________ Cell # : _____________________________ Other #: ________________________

E-Mail Address: ______________________ Referred By: ______________________

Physician: ____________________________ Phone #: _______________________
***Medications**: {Please list or provide a list of medications you are taking}*

Have you taken a premedication prior to dental appointments in the past?

If so, what and why?____

Are you allergic to or have you had any reactions to the following:

Local Anesthetics (i.e. Novocaine}: _______ Sulfa Drugs: _______ Barbiturates: _______ Iodine: ______
Sedatives: _______ Penicillin or other antibiotics: _______ Latex Rubber: ______ Ibuprofen: ______
Other: ____

Do you have or have you had any of the following?

Heart related:

High/Low Blood Pressure______	*Respiratory Problems____*	*Joint Replacement____*	*Arthritis ____*
Heart Disease ____	*Asthma ____*	*Frequently Tired ____*	*Thyroid ____*
Heart Attack ____	*Emphysema ____*	*HayFever/Allergies ____*	*Recent Weight Loss ____*
Stroke ____	*Cancer ____*	*Anemia ____*	*Hepatitis/Jaundice ____*
Angina ____	*Liver Disease ____*	*Glaucoma ____*	*Tuberculosis ____*
Mitral Valve Prolapse ____	*Kidney Disease ____*	*Fainting/Seizures ____*	*Aids/HIV ____*
Cardiac Pacemaker ____	*Tobacco Use ____*	*Epilepsy/Convulsions ____*	*Alcohol Use ____*
Rheumatic Fever ____	*Ulcers ____*	*Diabetes___ (Type 1 ___ Type 2___)*	

Women Only: Pregnant ____ Nursing ____ Oral Contraceptives ____

Insurance information:

Patients are responsible for payment at time of service. As a courtesy to you, we will bill your dental insurance on your behalf. Your dental insurance will reimburse you directly. We do not accept assignment of dental insurance benefits. Ultimately, the contract you have with your dental insurance company is between you and the insurance company.

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third
party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf.

Signature of Patient/Guardian: _____________________________ Date: _________
Responsible Party {if other than Patient} _____________________ Date: _________

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 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 us. 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 protected health information (PHI) including electronic protected health information (ePHI) to provide you with our professional services which may include electronic disclosure. 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 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 person you chose 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. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act changed the accounting of disclosures to include these services, payment and business operations. Disclosures can be made available for a period of 6 years prior to your request. To request this list or accounting of disclosures, you must submit your request in writing to us. Lists, if requested, will be charged a fee for each page, and the staff time incurred will be charged per hour including the time required to locate and copy your health information. Please contact us for a fee schedule 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 services for which our facility has been paid out of pocket in full.

Payment: We may use and disclose your PHI and ePHI 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 judgement 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.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

Copy of Notice is located in the office waiting room

I, ____ have received a copy of Palm Ridge Dental's Notice of Privacy Practices.

____.
Please Print Name

____.
Signature

____.
Date

I authorize the following individuals access to my dental records:
____.
____.
____.

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*
__ *Communication barriers prohibited obtaining the acknowledgement*
__ *An emergency situation prevented us from obtaining acknowledgement*
__ *Other (Please Specify)*