

PATIENT INFORMATION

*Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.*

Patient's name _____ Preferred name _____ Birth date _____
If minor, parents name _____ Best contact phone number (_____) _____
Mailing address _____ City _____ State _____ Zip _____
Employer _____ Occupation _____
Spouse's name _____ Spouse's employer _____ Unmarried
How did you learn about our office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: Not covered by dental insurance
Your Social Security number: _____ Dental Insurance Co. _____ Group number _____
Covered by spouse's insurance? yes no Insurance Co. Phone _____
Spouse's dental insurance company _____ Group number _____
Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

**Do you have or have you had any of the following?
(PLEASE Circle YES or NO)**

Y N Cancer or tumor
Y N Heart ailment or chest pains
Y N Heart murmur, mitral valve prolapse, heart defect
Y N Osteoporosis
Y N Artificial joint or valve
Y N HIGH or LOW blood pressure (circle one)
Y N Pacemaker
Y N Tuberculosis or other lung problems
Y N Kidney disease
Y N Hepatitis or other liver disease
Y N Alcoholism
Y N Blood transfusion
Y N Diabetes
Y N Neurologic condition
Y N Epilepsy, seizures, or fainting spells
Y N Emotional condition
Y N Arthritis
Y N Herpes or cold sores
Y N AIDS or HIV positive
Y N Migraine headaches or frequent headaches
Y N Anemia or blood disorders
Y N Abnormal bleeding after extractions, surgery, or trauma
Y N Hay Fever or sinus trouble
Y N Allergies or hives
Y N Asthma
Do you smoke or use chewing tobacco? yes no

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

Latex materials
 Penicillin or other antibiotics
 Local anesthetics ("Novocain")
 Codeine or other narcotics
 Sulfa drugs
 Barbiturates, sedatives, or sleeping pills
 Aspirin
 Other: _____

Please list medications or supplements you take:

May be pregnant
Expected delivery date: _____
 Taking hormones or contraceptives

Name of your physician: _____ Emergency Contact AND Phone Number _____

List any family member with whom you give us permission to discuss treatment: _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

Reason for today's visit: _____

Signature of patient (or parent) _____ Date _____

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Patient Financial Agreement

Friendly Dental requires all patients to make financial arrangements with us before we provide treatment.

1. I understand that full payment is due at the time of service for myself and any party for whom I am financially responsible.
2. I understand that it is solely my responsibility to confirm which treatments or procedures are covered and/or paid by my insurance (including, but not limited to, any applicable exclusions, deductibles, annual or lifetime maximums).
3. I understand that although I pay my estimated patient balance on the date of service, the insurance estimate may differ from what my insurance carrier ultimately pays. I will be responsible for any amounts not paid by my insurance for any reason, and I may receive a bill/statement for a balance due which will be immediately payable upon receipt. Credit balances will remain on my account unless I request a refund.
4. I understand that as a courtesy, Friendly Dental will attempt to verify my insurance coverage from information that I provide and will file two claims per appointment, in accordance with all contracted agreements with the insurance payor(s). Your personal health information (PHI) may be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits. I am required to pay in full, before treatment is performed, the estimated portion of any procedures or treatment that will not be covered by my insurance.
5. I understand that insurance claims will only be filed if I provide Friendly Dental with my social security and insurance identification numbers (if applicable). If I choose not to provide Friendly Dental with my social security number, I understand that I must pay in full for all services rendered. It is Friendly Dental's policy to require social security numbers and a copy of a government-issued picture identification (driver's license) for recordkeeping purposes even though that may not be the policy of my insurance carrier.
6. I understand that Friendly Dental currently charges \$40.00 for a broken or cancelled appointment unless 24 hours advance notice is given. This fee is subject to change without notice.
7. I understand that unless patient records are sent directly to another provider, the charge for copies of x-rays is \$18.00 and treatment information is \$5.00 or the maximum amount allowed by law or my insurance carrier. These fees are subject to change without notice.
8. I understand that I must inform Friendly Dental, in writing, of any concerns, questions or disputes I may have concerning my treatment or charges in a timely manner, but not more than 30 days from either the completion of the procedure or awareness of dispute.

9. I understand that all account balances over 30 days will incur an interest charge at the maximum legal rate allowed.
10. I understand that I will be charged the maximum service charge allowed by law for any returned check, electronic authorization or any debit sent or provided to Friendly Dental for payment.
11. I understand that if I fail to pay my account upon it becoming due, Friendly Dental may report my account to credit rating bureaus or to a collection agency and/or take legal action against me for full payment, including but not limited to all related reasonable attorney's fees, collection and/or court costs.
12. I understand it is my responsibility to notify Friendly Dental of any changes to my address, phone number, insurance changes, etc.
13. I authorize payment of the dental benefits, otherwise payable to me, be made directly to Friendly Dental.
14. I understand that if I discontinue treatment for a requested procedure, including but not limited to, partials, dentures, crowns, bridgework and surgical preparatory work, I remain responsible for paying all lab related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled for discontinued treatment and I may receive a bill / statement for a balance due.
15. REFUND OF PRODUCTS: I understand that Friendly Dental's return policy for unopened or unused non-prescription products is thirty(30) days from the date of purchase. Non-prescription products include, but are not limited to, toothbrushes, or other non-prescription merchandise. By law, prescription products cannot be returned which include but are not limited to, whitening products or toothpastes.

I have thoroughly read, understand and agree to the above terms and conditions.

Printed Name

Date

Signature of Patient (or authorized guardian)

If authorized guardian, relationship to patient



16520 S. Tamiami Trl, Ste 106
Fort Myers, FL 33908

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 May 10, 2016 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 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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.

Restrictions: 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: Robin Mamo
Telephone: 239-529-4159
Fax: 239-790-4475
E-Mail: friendlydentalarts@gmail.com
Address: 16520 S. Turniami Trl, Ste. 106
Fort Myers, FL 33908



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Fort Myers, FL 33908

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's Notice of Privacy Practices.
(PLEASE PRINT NAME)

Signature

Date

*You May Refuse To Sign This Acknowledgement

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)

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PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the results of tests, treatment plans, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Friendly Dental, PA to release my records and any Information requested to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

Patient Name (PLEASE PRINT)

Date

Patient Signature