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** (_______)__________________

Email: ______________________________

Mailing address ______________________ City ______________ State _______ Zip __________

Employer ____________________ Occupation ______________________________

Spouse's name __________________ Spouse's employer ____________________ ❑ Unmarried

How did you learn about our office? ______________________________

Medical Health History

Do you have or have you had any of the following? **(PLEASE Circle YES or NO)**	Are you allergic to, or have you reacted adversely to any of the following?
Y N Cancer or tumor	❑ Latex materials
Y N Heart ailment or chest pains	❑ Penicillin or other antibiotics
Y N Heart murmur, mitral valve prolapse, heart defect	❑ Local anesthetics ("Novocain")
Y N Osteoporosis	❑ Codeine or other narcotics
Y N Artificial joint or valve	❑ Sulfa drugs
Y N HIGH or LOW blood pressure (circle one)	❑ Barbiturates, sedatives, or sleeping pills
Y N Pacemaker	❑ Aspirin
Y N Tuberculosis or other lung problems	❑ Other:____________________
Y N Kidney disease	
Y N Hepatitis or other liver disease	Please list medications or supplements you take:
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	❑ May be pregnant
Y N Allergies or hives	Expected delivery date: __________
Y N Asthma	❑ Taking hormones or contraceptives
Do you smoke or use chewing tobacco? ❑ yes ❑ no	

Name of your physician:________________ **Emergency Contact AND Phone Number**____________________

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 pay in full at the time services are rendered.

1. **I understand that Friendly Dental currently charges a fee for any broken, canceled, changed, non confirmed or moved appointment unless 48 hours advance notice is given. This fee is subject to change without notice.**

2. I understand that full payment is due upon scheduling any service for myself and any party for whom I am financially responsible.

3. Out of network benefits and reimbursements can not be verified nor guaranteed by Friendly Dental. We encourage all patients with out of network plans to contact their insurance company directly.

4. I understand it is my responsibility to notify Friendly Dental of any changes to my address, phone number, insurance changes, etc.

5. 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.

6. 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 the dispute.

7. REFUND OF PRODUCTS: I understand that Friendly Dental's return policy for unopened or unused non-prescription products is fifteen (15) 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

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Signature of Patient (or authorized guardia

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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.

16520 S. Tamiami Trl, Ste 106
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

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