PERSONAL INFORMATION

Patient Name _____Age____ Sex____ Date of Birth _____
Parent Name (if minor)_____
Patient Social Security # _____
Address _____Home Phone_____
City _____Zip_____ Cellular Phone_____
Employer _____ E-mail Address _____
Address _____Work Phone _____
_____Zip_____
Spouse Name _____ Employer _____
Address_____ Work #_____
_____ Zip_____

INSURANCE INFORMATION

Dental/Medical Insurance Company _____Group #_____
Policy Holders Name_____ Date of Birth_____
Identification #_____
Claims Office Address _____ Telephone #_____
City_____Zip_____

In case of emergency: Name& Phone# _____
Whom may we thank for referring you to our office? _____
Who is responsible for payment? _____
How do you plan to pay for this appointment? ____ Cash ____visa/MasterCard ___other

OUR OFFICE POLICY

Our goal is to provide you with the best possible dental care. In order to do so we must schedule appointments to provide the proper amount of time for each dental procedure. Our fees are based on this time. It is important that you arrive on time. In the event you must cancel or reschedule your appointment please notify us at least one working day in advance.

If you fail to show for your appointment you may be charged for the entire appointment if we are unable to fill this time. Occasionally we must work emergency patients into the schedule. If this occurs we will make every effort to stay on time and to notify you in advance. Your patience is appreciated. If you ever have a dental emergency, we will afford you this same courtesy.

Our office does not accept assignment from insurance companies, we will gladly submit your claim and complete the follow up necessary to assist in reimburse to you for services rendered. Payment is expected when services are rendered unless prior arrangements have been made with the office manager.

I consent to the taking of x-rays before, during and after treatment, as they are necessary part of the diagnostic procedure and record keeping. In the event that models are taken and treatment is not performed, Dr. Thomas M. Walsh will store these models for a period of one year. I further give permission for the use of these photographs, x-rays and records to be use for the purpose of research, education or publication of professional journals.

Patients Signature(or parent if minor)

_____Date_____

MEDICAL HISTORY

Patient Name_____

Patient Physician_____ Office Number_____

Approximate date of last exam_____

1. Have you been under the care of a medical doctor during the past two years? ---------- YES NO
2. Have you been a patient in a hospital in the past two years? ---------- YES NO
3. Have you taken any medicines or drugs during the past two years? ---------- YES NO
4. Are you allergic to (i.e. itching, rash, swelling, of hand, feet, or eyes, breathing problems) or made sick by penicillin, codeine, or any other drug or medication? List if applicable: YES NO
5. Have you ever had any excessive bleeding requiring special treatment? ---------- YES NO
6. CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

MITRAL VALVE PROLAPSE	**ARTIFICIAL JOINT**	**PAIN IN JAW JOINTS**
HEART MURMUR	**EMPHYSEMA**	**EPILEPSY OR SEIZURES**
HEART FAILURE	**COUGH**	**HEPATITIS A**
HEART DISEASE OR ATTACK	**TUBERCULOSIS (TB)**	**HEPATITIS B**
ANGINA PECTORIS	**ASTHMA**	**HEPATITIS C**
ARTIFICIAL HEART VALVE	**HAY FEVER**	**LIVER DISEASE**
HEART PACEMAKER	**SINUS TROUBLE**	**YELLOW JAUNDICE**
HEART SURGERY	**ALLERGIES OR HIVES**	**BLOOD TRANSFUSION**
SCARLET FEVER	**DRUG ADDICTION**	
RHEUMATIC FEVER	**THYROID DISEASE**	
STROKE	**COLD SORES**	
HIGH BLOOD PRESSURE	**GENITAL HERPES**	
CHEMOTHERAPHY (CANCER/LEUKEMIA)	**AIDS**	
ANEMIA	**ARTHRITIS**	
KIDNEY TROUBLE	**FAINTING OR DIZZY SPELLS**	
ULCERS	**NERVOUSNESS/ DEPRESSION**	
GLAUCOMA	**GONORHEA/SYPHILIS**	
SICKLE CELL DISEASE	**MULTIPLE SCLEROSIS**	
RHEUMATISM OR RHEUMATOID ARTHRITIS	**ACID REFLUX**	
X-RAY, COBALT OR RADIATION TREATMENT	**CORTISONE MEDICINE**	
DIABETES		
HEMOPHILLIA	**PSYCHIATRIC TREATMENT**	

MEDICINES

ALLERGIES

7. When you walk upstairs or that a walk do you ever have to stop because of pain in your chest or shortness of breath, or become tired? ---------- YES NO
8. Do your ankles swell during the day? ---------- YES NO
9. Do you use more than two pillows to sleep? ---------- YES NO
10. Have you lost or gained ten pounds in the last year? ---------- YES NO
11. Do you ever wake up from sleep short of breath? ---------- YES NO
12. Are you on a special diet? ---------- YES NO
13. Has your medical doctor ever said you have a cancer or tumor? ---------- YES NO
14. Do you have any disease, condition not listed above? ---------- YES NO
15. **WOMEN:** Are you pregnant? ---------- YES NO
    Are you practicing birth control? ---------- YES NO
    Do you anticipate becoming pregnant? ---------- YES NO
16. Are you having pain or discomfort at this time? ---------- YES NO
17. Do you feel nervous about having dental treatment? ---------- YES NO
18. Have you ever had a bad experience in a dental office? ---------- YES NO
19. Do you smoke? _____ How many packs per day? _____
20. Do you drink alcohol? ---------- YES NO
21. Have you ever had periodontal (Gum) treatment? ---------- YES NO
22. Have you ever had any form of orthodontic treatment (braces, retainers, space holders)? ---------- YES NO
23. Do you ever clench or grind your teeth? ---------- YES NO
24. Do you ever have clicking or popping in your jaw? ---------- YES NO
25. Do you have headaches, ear aches or jaw pain? ---------- YES NO
26. When was your last dental exam?_____ When were you last radiographs taken?_____

To the best of my knowledge all of the proceeding answers are true and correct. If I ever have any change in my health, or if my medication changes I will inform the doctor of dentistry at the next appointment without fail.

Signature_____ Date_____

Witness _____Date_____

Dr. Thomas Walsh II, D.D.S.,P.A.
103071 Overseas Hwy
Key Largo, FL 33037

(305)451-8005

Dear Patient,

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

____Payment by cash

____Payment by check

____Payment by credit card (VISA/MASTER CARD)

____Automatic monthly billing to your VISA /MASTER CARD/CARE CREDIT

Please make your choice, sign below and return to office manager before treatment.

_____Print your name DATE:_____

_____Sign your name here

IMPORTANT INSURANCE INFORMATION

Please read carefully and sign when finished

Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception- **DENTAL INSURANCE WAS NOT DESIGNED TO PAY FOR ALL DENTAL CARE.** *Most contracts have limits and/ or various degrees of co-payment.*

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is **NEVER** *based on what you insurance company will pay; your treatment should not be governed by your insurance contract.*

However, it should be understood, that ***the dental insurance contract is between the insurance company and the patient****, whom bears the ultimate financial responsibility. Meaning; if we agree to take your assignment, the final balance is your responsibility and by signing this form, you agree to pay in a timely manner.*

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance.

I have read & understand the above information.

_____

Patient signature *Date*

Thomas M. Walsh II DDS

103071 Overseas Highway

Key Largo, FL 33037

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.

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, 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 applicable law permits the changes. 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, 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 health care operations. For example:

TREATMENT: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

HEALTH CARE OPERATIONS: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

ON YOUR AUTHORIZATION: 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 uses or disclosures permitted by your authorization while it was in effect. Unless you give us a 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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 medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

APPOINTMENT REMINDERS: We may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

DISASTER RELIEF: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

PUBLIC BENEFIT: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting. FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To an organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

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 of your health care information. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost based fee that may include labor, copying costs, and postage. If your request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to-prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last six years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

RESTRICTION: 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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

AMENDMENT: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. 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.

Thomas M. Walsh II DDS

(305) 451-8005

103071 Overseas Highway

Key Largo, FL 33037

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Thomas M. Walsh II D.D.S., this _____ day of_____, 20_____.

A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____

PLEASE PRINT YOUR NAME

_____

PLEASE SIGN YOUR NAME

If you are the legal representative of the patient please print the patients' name(s) and describe your authority:

_____

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer.

Office Use Only As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

_____ It was emergency treatment.

_____ I could not communicate with the patient.

_____ The patient refused to sign.

_____ The patient was unable to sign because: _____

_____.

_____ Other (please describe): _____ _____

_____.

Signature of privacy officer:_____