Dental/Medical History Form

Name _____ Social Security #_____/_____/_____
FIRST MIDDLE LAST

Date of birth _____/___/_____ Age _____ Male/ Female Status: Married /Single /Divorced / Widowed / Separated

Address _____

City _____ State_____ Zip _____

Home Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____

Primary Dental Insurance
Insurance Co. Name: _____
Insurance Co. Phone #: (____)_____
Policy # _____
Group # _____
Insured's Name: _____
Insured's Birth date:_____/_____/_____
Insured's SS#_____
Insured's Employer: _____

Secondary Dental Insurance
Insurance Co. Name: _____
Insurance Co. Phone #: (____)_____
Policy # _____
Group # _____
Insured's Name: _____
Insured's Birth date:_____/_____/_____
Insured's SS#_____
Insured's Employer: _____

Person Responsible for Account:_____
Work #: (____)_____Ext:_____ Home #:(____)_____
Billing Address: _____
Relation: _____ SS #:_____
Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name:_____ Relation:_____Wk #: (____)_____ Hm #: (____)_____

1. What is your primary dental complaint?_____
2. When was your last dental cleaning?_____ Your last complete dental exam?_____
3. Your last Full mouth X-Ray or Panorex? _____
4. Are you satisfied with your smile? Yes /No If No, Why? _____
5. Have you ever been told you have, or have symptoms of gum disease (bleeding gums, sore gums, bad taste or odor in the mouth, loose teeth)? Yes/ No
6. Do you suffer from frequent migraine headaches or have problems with your Jaw Joint? Yes/ No

Please list any medications you are currently taking:

For the following questions please circle all answers that apply, if none apply please check none:

Heart Murmur	Rheumatic Fever	Vascular Shunt	High Blood Pressure	Coronary Occlusion
Arteriosclerosis	Stroke	Heart Attack	Chest Pain	**Artificial Heart Valves_____**
Heart Defect	Pacemaker	Heart Surgery	Congestive Heart Failure	**Artificial Joints_____**
AIDS/ HIV	Hepatitis	Tuberculosis	**Sexually Transmitted Disease**	**NONE**

DR. DOUGLAS A. FLORENCE, D.D.S * 417 GRAND PARK DRIVE, SUITE 109 * PARKERSBURG, WV 26105
PHONE (304) 422-4455 * FAX (304) 422-4458

Are you allergic to any of the following: Circle all that apply

Penicillin	Sulfa	Erythromycin	Local Anesthetics	Other Medicine _____
Codeine	Nickel/Other Metals	Latex	Keflex	**No Allergies**

Do you have, or have you had, any problems with the following: Circle all that apply

Sinus Trouble	**Asthma**	Bronchitis	Emphysema	Other Respiratory Problems
Diabetes	Thyroid Disorder	Liver Problems	Kidney/Adrenal Problems	Jaundice
Digestive Problems	Colitis	Stomach Ulcer	Hiatal Hernia	Muscle or Bone Disease
Neurological Problems	Fainting	Seizures	**Epilepsy**	Mental Health Problems
Depression	Abnormal Bleeding	**Clotting Problems**	Phlebitis	Anemia Transfusions
Cancer	Tumor(s)	Cyst	Biopsy	Arthritis
Are you Pregnant?	Nursing?	Taking Birth Control?	Other_____	Other_____

Do you: Circle all that apply

Smoke	Drink Alcohol	Use Illegal Drugs	Use Chewing Tobacco/Snuff			

Have you ever been : Hospitalized / Operated on **Describe:**_____

Treated for any other conditions not on this form?_____

I understand that this medical history is a legal document and that I have answered all of the above questions to the best of my ability and knowledge and I will not hold Dr. Florence or any other staff members responsible for any errors or omissions I have made in the completion of this form.

X _____ **X** _____ _____

Print Patient Name | Patient/Guardian Signature | Date

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FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments.

Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available through CareCredit upon request and approval.

Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Additionally, our office reserves the right to charge you for appointments that you do not keep and for appointments that you do not cancel with 48-hour notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

X _____ **X** _____ _____

Print Patient Name | Patient/Guardian Signature | Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of The Florence Dental Group's Notice of Privacy Practices.

X_____ **X** _____ _____

Print Patient Name | Patient/Guardian Signature | Date

_____ _____

Signature of Representative for The Florence Dental Group | Date

DR. DOUGLAS A. FLORENCE, D.D.S * 417 GRAND PARK DRIVE, SUITE 109 * PARKERSBURG, WV 26105
PHONE (304) 422-4455 * FAX (304) 422-4458

The Florence Dental Group

Dr. Douglas A. Florence, D.D.S.
417 Grand Park Drive • Suites 108 & 109
Parkersburg, WV 26105
(304) 422-4455

RELEASE OF DENTAL RECORDS

PATIENT'S NAME:_____BIRTHDATE:_____/_____/_____
ADDRESS:_____CITY:_____STATE:_____ZIP:_____

I HEREBY AUTHORIZE THE OFFICE OF _____ TO RELEASE <u>COPIES OF MY ENTIRE DENTAL RECORDS</u>, <u>COPIES OF ANY X-RAYS TAKEN WITHIN THE LAST THREE YEARS,</u> <u>AND ANY OTHER PERTINENT MEDICAL INFORMATION</u> NECESSARY FOR THE PURPOSE OF TREATING MY DENTAL NEEDS TO THE FLORENCE DENTAL GROUP AT THE ABOVE ADDRESS.

I UNDERSTAND THAT:

1. **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY DENTAL CARE OR THE PAYMENT FOR MY DENTAL CARE.**
2. **I HAVE A RIGHT TO A COPY OF THIS FORM AFTER I SIGN IT.**
3. **I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE FLORENCE DENTAL GROUP IN WRITING.**

_____ _____
PRINT PATIENT'S NAME **SIGNATURE OF PATIENT OR GUARDIAN**

_____ _____
RELATIONSHIP TO PATIENT **TODAY'S DATE**

<u>OFFICE USE ONLY:</u>

_____ _____
_____ **DATE REQUEST SENT**
_____ _____
ADDRESS REQUESTED RECORDS FROM **DATE REQUESTED INFORMATION RECEIVED**

_____ _____
SIGNATURE OF REPRESENTATIVE FOR THE FLORENCE DENTAL GROUP **TODAY'S DATE**

Dr. Douglas A. Florence, D.D.S.
417 Grand Park Drive • Suites 108 & 109
Parkersburg, WV 26105
(304) 422-4455

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please ask the front office staff or contact The Florence Dental Group at 304-422-4455.

WHO IS COVERED BY THIS NOTICE

This notice describes the dental practice of The Florence Dental Group.
The Florence Dental Group and staff may share health information with each other for treatment, payment or health system operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION

We are required by law to:

- make sure that your health information is kept private;
- give you this notice of our legal duties and privacy practices; and
- follow the terms of the notice currently in effect.

We understand that your health information is personal. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. We are committed to protecting this information.
This notice will tell you about:

- the ways in which we may use and disclose your health information;
- your rights; and
- our obligations regarding the use and disclosure of health information.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use or share your health information in certain ways. We will explain how and when we may use or share your health information. We are not able to list each specific way we may use or share your health information, but each situation will fall into one of the basic categories:

- **For Treatment**. It is important that we be able to use or share your information to treat you. We may share your information with doctors, nurses, assistants, dental hygienists, or other personnel who are involved in taking care of you. Staff members also may share health information about you in order to coordinate the different things you need, such as prescriptions or x-rays. We may share your information with health care providers outside of The Florence Dental Group's practice for your treatment.
  For example, a dentist treating you may need to contact your medical doctor regarding your recent heart condition. Or a health care provider may need to know about any drug allergies that you have in order to provide you with appropriate medication.
- **For Payment.** We may use or share your health information so that we are paid for the services provided. We may share your information with another provider so that they may be paid for services as well. We may bill, and share information with other providers, an insurance company, you, or a third party. For example, we may need to give your health plan information about your diagnosis and treatment so your health plan will pay us or reimburse you for the care we provided. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also share your health information in order to facilitate payment to another provider who has participated in your care.
- **For Health Care Operations**. We may use and share your health information for The Florence Dental Group's practice operations. These uses and disclosures are necessary for business operations and to make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services should be offered, what services are not needed, and whether certain new treatments are effective. We may review and evaluate your health information with health information from others to compare how we are doing and see where we can make improvements in the care and services we offer.
- **Appointment Reminders**. We may use and disclose health information to contact you as a reminder that you have an appointment for treatment at The Florence Dental Group's office. We currently use an automated telephone call for your appointment reminder 48 hours in advance of your appointment. A staff member may also call as a reminder of an appointment. Information may also be sent in the mail via letter or postcard.
  If you do not wish to receive appointment reminders, or wish to be contacted at a certain telephone number, please contact The Florence Dental Group's office at 304-422-4455.
- **Health-Related Benefits and Services**. We may use and disclose health information to tell you about treatment options, health-related benefits, or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care**. We may release information about you to a family member or other designated person who is involved in your care. We may also give information to someone who helps pay for your care. For example, we may need to tell the person who comes with you to an appointment what he or she may need to do to help you once you get home. In the event of an emergency, we may need to use or share information about you in order to inform your family or persons responsible for your care where you are and your condition.

SPECIAL SITUATIONS: Additional uses and disclosures for which authorization or opportunity to agree or object is not required by federal privacy rules.

- **As Required By Law**. We may use or disclose your health information without your written authorization if we are required to do so by federal, state or local law. Any disclosure will be strictly limited to the requirements of the law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person.
- **Workers' Compensation**. We may release medical information to Workers' Compensation, as required by workers' compensation laws. This program provides benefits for work-related injuries or illness.
- **Public Health Risks**. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; and/or reporting disease or infection exposure.
- **Victims of Abuse, Neglect, or Domestic Violence.** We may disclose certain health information to government agencies authorized by law to receive reports of abuse, neglect, or domestic violence if we believe that you have been a victim.

- **Health Oversight Activities**. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.
- **Judicial and Administrative Proceedings.** We may disclose your health information in the course of an administrative or judicial proceeding, such as in response to a court order.
- **Law Enforcement**. We may release health information to a law enforcement official if required or permitted by law.
- **Deceased Person Information.** We may release health information to a coroner or medical examiner, or a funeral director as necessary to carry out their duties as required or permitted by law.
- **Specialized Government Functions.** We may release health information about you to authorized federal officials for national security and intelligence, military, or veteran's activities required by law.
- **Secretary of the Department of Health and Human Services.** We may be required to disclose health information without your written authorization to the Secretary of the Department of Health and Human Services when directed to do so in order to review our compliance with federal privacy rules.

USES OF HEALTH INFORMATION THAT REQUIRE AUTHORIZATION

In all other situations (situations that are not treatment, payment, operations or special situations), we may only share information with your specific written authorization.

You may revoke that authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we already have used or disclosed your information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although our business record consists of your health information or designated record set, which includes information we used to make decisions about your care, and is the property of The Florence Dental Group, the information contained in those records is your information, and you have certain rights regarding that information. You have the following rights regarding health information we maintain about you. If you wish to exercise any of these rights, please send or submit a written request to The Florence Dental Group, 417 Grand Park Drive, Suite 109, Parkersburg, WV, 26105.

- **Right to Review and Obtain a Copy**. You have the right to inspect and obtain a copy of health information that may be used to make decisions about your care. Usually, this information includes treatment and billing records, but does not include psychotherapy notes, information compiled for use in or created in anticipation of a civil, criminal or administrative action or proceeding, or certain lab test results subject to the Clinical Laboratories Improvement Act of 1988. You must submit a request for your health information in writing to The Florence Dental Group, 417 Grand Park Drive, Suite 109, Parkersburg, WV, 26105.

  Right to Appeal a Denial of Access to Health Information.

  You have the right to access your health information. There are some limitations on that right. If for clear treatment reasons your health provider has determined that access to your health information is likely to have an adverse effect on you, the health care provider shall provide the record to a practitioner designated by you to help you with your review of the information.

  Your access is limited to your designated record set. Your designated record set is information we used to make decisions about your care. It does not include:
  - information compiled for use in or created in anticipation of a civil, criminal or administrative action or proceeding, or
  - certain lab test results subject to the Clinical Laboratories Improvement Act of 1988, or
  - other types of information that we did not use to make decisions about your health care.
- **Right to Amend.**

  If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained. We may deny your request if you ask us to amend information that:
  - is not part of the information which you would be permitted to inspect and copy; or
  - we believe is accurate and complete.

  Submit your request to The Florence Dental Group, 417 Grand Park Drive, Suite 109, Parkersburg, WV, 26105. Your request must be made in writing and include a reason that supports your request.
- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." An accounting of disclosures is a list of the disclosures we made to others of health information about you that are not related to treatment, payment, health care operations, certain disclosures required by law to be kept confidential or disclosures you specifically authorized.

  You must submit your request in writing to The Florence Dental Group, 417 Grand Park Drive, Suite 109, Parkersburg, WV, 26105. Your request must:
  - tell us the calendar dates you want to see. The time period cannot include more than six years of information, and cannot begin prior to June 16, 2008.
  - indicate in what form you want the list (paper copy or electronic).
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. ***We are not required to agree with your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  You must make your request for any restrictions in writing to The Florence Dental Group, 417 Grand Park Drive, Suite 109, Parkersburg, WV, 26105. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).
- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  You must make your request for confidential communications in writing to The Florence Dental Group, 417 Grand Park Drive, Suite 109, Parkersburg, WV, 26105. While we are not required to agree with your request, we will try to accommodate all reasonable requests. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. For example, if you wish to be contacted by telephone, be sure to provide an appropriate telephone number.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Contact a member of the office staff for a copy. If you have any questions about how to access this information, please ask the front office staff or contact The Florence Dental Group at 304-422-4455.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. Current copies of this notice will be available at our office. The effective date of the notice will be posted on the top of the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with The Florence Dental Group, 417 Grand Park Drive, Suite 109, Parkersburg, WV, 26105 or with the U.S. Office of Civil Rights, Washington, DC. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**