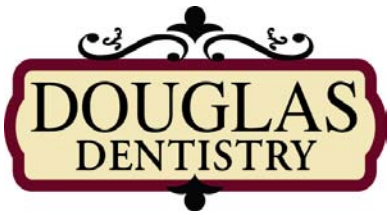

Patient Information
Last Name:_____ First Name:_____Preferred Name:_____
Address:_____City:_____State/Zip:_____
Home Phone_____Cell Phone:_____
Work Phone:_____ Social Security Number:_____
Sex: M F Date of Birth:_____ Height:_____ Weight:_____
Email Address:_____

Responsible Party (Minors Only)
Name:_____ DOB:_____ SS#:_____
Address:_____City:_____State/Zip:_____
Home Phone:_____Cell Phone:_____
Relationship to Patient:_____ Work Phone:_____

Dental Insurance
Insured Name:_____ DOB:_____SS#:_____
Employer:_____ ID#:_____
Insurance Company:_____ Phone:_____

Social History
Martial Status: ____S ___M ___W ___D Spouse's Name:_____
Work Status: __Employed __ Unemployed __Retired __Student Work Phone: _____
Employer/School:_____ Past/Present Occupation:_____
Hobbies/Activities:_____
Do you currently smoke/dip? Yes No Have you in the past? Yes No How long ago?_____
How many packs do/did you smoke a day? _____ Do you use recreational drugs? Yes No

Primary Care Physician
Physician:_____ Phone:_____
Specialist:_____ Phone:_____
When did you see them last?_____

How did you find out about Douglas Dentistry?
Referred by:_____
___Sign
___Newspaper
___Insurance Company
___Other_____
___Mailer
___Internet
___Brochure
___Neighborhood News

Do you have any other family members that come to Douglas Dentistry?_____
If so, who?_____

PLEASE TURN PAGE OVER

Dental History

Please check any of the following problems that apply to you.

□ Sensitivity (hot, cold, sweet)
Where? UR LR UL LL
□ Headaches
□ Jaw or joint pain
□ Teeth or fillings breaking
□ Grinding or clenching teeth
□ Bleeding, swollen, or irritated gums
□ Loose, tipped, or shifting teeth
□ Bad breath

Do you have any of the following?

□ Dentures
□ Partial dentures
□ Braces
□ Periodontal (gum) treatments

Please share the following dates:

Last cleaning _____
Last oral cancer screening _____
Last complete x-rays _____

Name of Previous Dentist _____
City _____ State _____
Why did you leave your previous dentist?
_____

Medical History

Please check any of the following that apply.

□ HIV/ AIDS
□ Anxiety / Depression
□ Artificial Heart Valves _____
□ Artificial Joints_____
□ Asthma
□ Cancer _____
□ Diabetes
□ Excessive bleeding
□ Glaucoma
□ Heart Murmur
□ Heart Disease
□ Heart Attack
□ Head Injury
□ Hepatitis A B C
□ High Blood Pressure
□ Kidney disease

Do you have any drug allergies?

□ Penicillin □ Codeine
□ Erythromycin □ Valium
□ Sulfa □ Darvocet
□ Tetracycline □ Percocet
□ Latex □ Local anesthetic
□ Other _____

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	□	□
If you could change your smile, you would:		
Make them whiter?	□	□
Make them straighter?	□	□
Close spaces?	□	□
Replace black metal fillings with tooth colored fillings?	□	□
Repair chipped teeth?	□	□
Replace missing teeth?	□	□
Replace old crowns that don't match?	□	□
Have a smile make over ?	□	□

On a scale of 1 -10 with 10 being the highest:

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10+
Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10+
What is the most important thing to you about your dental visit today?
_____
What is the most important thing to you about your future smile and dental health?
_____

□ Liver disease
□ Low Blood Pressure
□ MRSA
□ Osteoporosis
□ Pacemaker or Defibrillator _____
□ Pregnant or Breast Feeding Currently _____
□ History of Radiation Treatment _____
□ Respiratory Problems
□ Rheumatic Fever
□ Seizures
□ Stroke _____
□ Thyroid Disease
□ Tuberculosis
□ Ulcers
□ Venereal Diseases
□ Other _____

List any medications you are currently taking.

_____
_____
_____

Are you or have you taken any medications to strengthen your bones (i.e. Fosamax, Actonel, Evista)? □ yes □ no_____

Date _____ **Signature** _____

DOUGLAS DENTISTRY FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider! We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due in full at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express. Outside financing is available upon request and approval.

Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection/court cost and any attorney's fees associated with such collection.

Trying to accommodate every patient's individual needs and work schedules can be difficult, but we do our best. We work very hard to stay on schedule to minimize your waiting time in our office. A scheduled appointment is a commitment of time between the doctor and the patient. We have reserved that time JUST FOR YOU. When appointments are missed or canceled at the last minute, that time is lost. We ask that when you schedule your treatment, you make every effort to keep that commitment. We do understand that personal emergencies do arise, and we always take that into consideration. However, if you find that you cannot keep your scheduled appointment, a minimum of a **48 hour notice** will allow us to schedule another patient in need of treatment. It is our policy that with less than a **48 hour notice** on a change of commitment, a **charge of $50.00** may be considered and may be applied to your account.

IF YOU HAVE DENTAL INSURANCE**:**

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- 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 your insurance company. Our office is not a party to that contract.
- We ask that you inform us immediately upon any changes in your insurance coverage. Failure to do so may result in the inability of our office to file your claim, and thus you will be responsible for payment in full regardless of your insurance situation.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- You shall pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days form the time of filing. If your insurance company has not made payment within 60 days, you must contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient or guardian signature: _____ Date: _____

DOUGLAS
DENTISTRY

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 duty, 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 10/15/02, 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 policy 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 and 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 effect any use 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 must disclose your health information to you to notify, as described in the Patient Rights sections 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 safety or the health of 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 authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $15.00, per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will 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 a full explanation of our fee structure.)

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.

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).

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 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 you complaint with the U.S. Department of Health and Human Services.

Contact Officer: Pam
Telephone: 813-920-2326 Fax: 813-920-9836
E-mail: careodessafamilydentistry@ident.com
Address: 8734 N. Mobley Road Odessa, FL 33556

DOUGLAS
DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have read / received a copy of this office's Notice of Privacy Practices.

X _____
Please Place Your Signature Above

Date: _____

OFFICE USE ONLY BELOW

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ **Communications barrier prohibited obtaining the acknowledgement**

_____ **An emergency situation prevented us from obtaining acknowledgement**

_____ **Individual refused to sign** _____ **Staff Initials**

Other (please specify in writing below):

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*You may request a copy of our office's Notice Of Privacy, please let our staff know so that we may provide you with one.