Date: _____

*Office Use Only*
*Chart #:*_____

**WELCOME!**

*Please provide your license, dental and medical insurance cards for our records. (We do not accept Medicare.)*

## Patient Information

Patient Name: _____
Last, First MI (Preferred Name)

Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Date of Birth: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

E-Mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Whom may we thank for referring you to our office? _____

Do you have dental Insurance? ☐ Yes ☐ No Name of Insurance: _____

Pharmacy Name & Phone Number: _____

Address: _____
Street Suite #

_____
City State Zip Code

## Spouse or Responsible Party Information

(only fill out if different than patient)

Patient's relationship to responsible party: ☐ Spouse ☐ Child ☐ Other _____

Name: _____
Last, First MI (Preferred Name)

Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Date of Birth: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

E-Mail: _____

Address: _____
Street Apartment # City, State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street Apartment # City, State Zip Code

**DENTAL HISTORY**

What is your primary reason for this dental appointment? _____

_____

How often do you brush? _____ Floss? _____

When was your last dental cleaning? _____

How often do you get your teeth cleaned? _____

When were your last x-rays? _____

Name of Previous Dentist: _____ Phone: _____

Do you see a periodontist? ☐ Yes ☐ No

Name of Periodontist: _____ Phone: _____

Does food catch between your teeth? Where? _____ ☐ Yes ☐ No

Do your gums ever bleed? When? _____ ☐ Yes ☐ No

Do you suffer from dry mouth? _____ ☐ Yes ☐ No

Do you ever have popping, clicking, or discomfort in your jaw joint? _____ ☐ Yes ☐ No

Do you clench or grind? When? _____ ☐ Yes ☐ No

Do you smoke? How much? _____ ☐ Yes ☐ No

Do you chew tobacco? How much? _____ ☐ Yes ☐ No

E-Cigarette? How much? _____ ☐ Yes ☐ No

Do you snore? _____ ☐ Yes ☐ No

Do you stop breathing when asleep? _____ ☐ Yes ☐ No

Do you wake up exhausted in the morning? _____ ☐ Yes ☐ No

Do you wear a C-PAP? _____ ☐ Yes ☐ No

## Health Information

| | | | |
|---|---|---|---|
| ☐ Acid Reflux | ☐ Cancer | ☐ Heart Murmur | ☐ Psychiatric Care |
| ☐ AIDS | ☐ Chest Pain | ☐ Hepatitis _____ | ☐ Radiation Treatment |
| ☐ Allergies | ☐ Diabetes Type: _____ | ☐ High Blood Pressure | ☐ Respiratory Problems |
| ☐ Codeine Allergy | ☐ Dizziness | ☐ Insomnia | ☐ Rheumatic Fever |
| ☐ Penicillin Allergy | ☐ Emphysema | ☐ Impaired Cognition | ☐ Rheumatism |
| ☐ Lidocaine Allergy | ☐ Epilepsy | ☐ Jaundice | ☐ Stomach Problems |
| ☐ Latex Allergy | ☐ Excessive Bleeding | ☐ Kidney Disease | ☐ Stroke |
| ☐ _____ | ☐ Fainting | ☐ Liver Disease | ☐ Substance Abuse |
| ☐ Anemia | ☐ Gastritis/Gerd | ☐ Mental Disorder | ☐ Thyroid Problems |
| ☐ Arthritis | ☐ Glaucoma | ☐ Mood Disorder | ☐ Tumors |
| ☐ Asthma | ☐ Head Injuries | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Atrial Fibrillation | ☐ Heart Attack | ☐ Pregnancy | ☐ Ulcers |
| ☐ Auto Immune Disease | ☐ Heart Disease | Due Date: _____ | ☐ Other: _____ |
| ☐ Blood Disease | | | |

- Do you have any artificial joints? ☐ Yes ☐ No

  If yes, please list where and when surgery was completed: _____

- Do you need to pre-medicate prior to your dental visits? ☐ Yes ☐ No

  If yes, please list the name and dosage: _____

**MEDICAL HISTORY**

Name of Physician: _____ Phone: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, explain: _____

Are you now under the care of a physician? _____ ☐ Yes ☐ No

If yes, explain: _____

Have you ever had oral sedation? _____ ☐ Yes ☐ No

Have you ever had IV sedation? _____ ☐ Yes ☐ No

When was the last time you were sedated? _____ ☐ Yes ☐ No

Have you ever had a bad reaction to local, oral, or IV sedation? _____ ☐ Yes ☐ No

Are you on a blood thinner? _____ ☐ Yes ☐ No

☐ Brillinta ☐ Eliquis ☐ Plavix ☐ Pradaxa ☐ Warfarin ☐ Xarelto ☐ Other: _____

Have you ever taken any medications for osteoporosis, osteopenia, bone cancer, multiple myeloma, or any other bone disease? _____ ☐ Yes ☐ No

Are you currently taking, or have you ever taken any of these medications or any other bisphosphonates?

☐ Actonel ☐ Boniva ☐ Fosomax ☐ Prolia ☐ Zometa ☐ Other _____

Please list any other medications you are currently taking: *(or give us a copy of your list for our records)*

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

**X** _____ _____

Signature of patient, parent or guardian — Date

_____ _____

Print name — Relationship to patient

*Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. The following is information regarding our insurance and financial policies.*

## Consent for Services and Financial Policy

**Fee For Service**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Our office practices a fee for service model. Payment is due at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

**Insurance**

Insurance is a contract between the insurer and the patient. It is the patient's responsibility to know and understand the terms, guidelines and limitations of the plan. It is also the patient's responsibility to advise us of any changes in their insurance, their address, or their employer.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare and submit the patient's insurance forms as a courtesy. Reimbursement will be mailed to the patient from his or her insurance carrier. However, this dental office will not render services on the assumption that our charges will be paid by an insurance company.

**Assignment of Benefits**

I understand that payment is due at the time of service. If in the event non-payment occurs, I agree to assign all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. The assignment of benefits allows the office of Garrett S. Dennis, D.M.D. to be paid directly by my insurance carrier or other benefit plan for the services Garrett S. Dennis, D.M.D. and his team provides me, my minor child, or other person(s) entitled to healthcare benefits for this admission.

**Medicaid**

We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

**Treatment Proposals**

I understand that the fee estimate listed for this dental care can only be extended for a period of twelve months from the date of the patient examination. The direction of treatment can change when the doctor is performing services based on his findings, at which time we will communicate with the patient any differentiation in the treatment plan.

**Minors**

A parent or legal guardian must authorize treatment and financial arrangements for all patients under the age of 18.

**Missed appointments**

Missed appointments represent a cost to us and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hrs. in advance of the scheduled appointment. If it becomes a frequent issue, we reserve the right to assess a fee.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone or e-mail me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

**X** _____ _____

Signature of patient, parent or guardian — Date

_____ _____

Print name — Relationship to patient

# HIPAA COMPLIANCE

## Acknowledgement of Receipt of Notice of Privacy Practice

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of our office Notice of Privacy Practice.

This notice is available in hard copy by verbally requesting a copy at the front desk or by calling (239)598-4333, or by submitting a request in writing to our HIPAA Privacy Officer at 2388 Immokalee Rd. Naples, FL 34110.

## Consent to Release of Information.

I authorize Garrett S. Dennis, D.M.D. and his team to release my medical information and supporting documents of same, as compiled in my record during this visit, in accordance with HIPAA law unless otherwise prohibited by the completion of a "PHI Special Restriction Request" form by the patient or patient's representative. I acknowledge that data from my record will be accessible to all healthcare providers participating in my healthcare treatment including, but not limited to, Garrett S. Dennis, D.M.D. his team, and/or dentist(s)/physician(s) to whom I am referred for further treatment.

I also acknowledge that my medical record will be made available to government agencies as required by law. I authorize Garrett S. Dennis, D.M.D. and his team to request pertinent dental/medical information and supporting documents from any healthcare providers participating in my healthcare treatment.

## Consent to Receive Communication

If at any time I, or a person I am responsible for, provides contact information (a wireless or landline telephone number, address, email) at which I may be contacted, I consent to receive communication in any manner, including but not limited to; automated emails, voice mails, written statements, texts, autodialed calls and pre-recorded messages, which could result in charges to me. This healthcare provider may pass this right on to its successors and assigns, other medical providers used during the course of treatment, affiliates, agents, and independent contractors, including, but not limited to, servicers and collection agents. This contact information may be used for treatment, payment, and operations.

I acknowledge that I am an authorized user of this contact information and that I have permission to use said contact information from the actual current subscriber of the information. It is my responsibility to update this healthcare provider with new and updated contact information and that, if I fail to update this information, I will hold the healthcare provider harmless for untimely notifications.

I certify that I have read and understand the contents of this form.

**X** _____ _____

Signature of patient, parent or guardian — Date

_____ _____

Print name — Relationship to patient

## HIPAA COMPLIANCE

### Protected Health Information (PHI) Disclosure Authorization

Representatives of Dr. Garrett Dennis's office may leave detailed messages at the following telephone number(s):

Phone #: _____ Phone #: _____

Emergency Contact Name: _____ Phone: _____

Patient E-mail Address: _____

By providing your e-mail address, you agree to receive email notices from us, including notifications regarding your patient account. *Emailed records sent to an unencrypted email address may be viewable by an unauthorized party. By selecting this delivery method you understand and accept the inherent risks of receiving records via email to the address you specify.

The office of Garrett S. Dennis, D.M.D. may release any information (copies of exams, test results, appointment times & dates, medical & financial information) to the person(s) you list below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that a copy of the Notice of Privacy Practices is available for my review at any time. This notice is available in hard copy by verbally requesting a copy at the front desk or by calling (239)598-4333, or by submitting a request in writing to our HIPAA Privacy Officer at 2388 Immokalee Rd. Naples, FL 34110.

I understand that the office of Garrett S. Dennis, D.M.D. may use or disclose my protected health information (PHI) for the purposes of medical treatment, payment, and healthcare operations. The office of Garrett S. Dennis, D.M.D. also share information in the following circumstances: • During a medical emergency, if the restricted information is needed to provide emergency care • For reporting abuse, neglect, domestic violence or other crimes • For health oversight activities, law enforcement investigations, judicial or administrative proceedings • For identifying decedents to the coroner, or determining cause of death • For worker's compensation programs • For uses or disclosures otherwise required by law • For the Business Associates (BA) performing services on behalf of the office of Garrett S. Dennis, D.M.D. as noted in the Notice of Privacy Practices.

I understand that I can revoke this authorization at any time by written request. I understand that the office of Garrett S. Dennis, D.M.D. may not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to applicable privacy laws.

I certify that I have read and understand the contents of this form.

**X** _____ _____

Signature of patient, parent or guardian — Date

_____ _____

Print name — Relationship to patient

# Broken Appointment Policy

We have more patients who need dental care than we have room in our daily schedule to provide. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who needs dental care. This policy is our attempt to ensure that both you and our other patients receive the dental care that you need.

**Broken Appointments:** If a patient misses their appointment or cancels short notice, (under 24 hrs.) they will be assessed a $50 missed appointment fee. Patients who have broken three appointments with us in a 12 month period, will not be scheduled another appointment.

- Broken appointments are any time you are scheduled for an appointment and you do not show for that appointment.
- Late cancelations are considered broken appointments. If you need to cancel your appointment, please call us at least 24 hours before your appointment time.
- Late arrivals are also considered broken appointments. If you do not arrive by 15 minutes after the start time of your appointment, it may be given to another patient in need.

**Appointment Confirmation:** You must confirm your appointment at least 24 hours before your appointment time. (Either by our confirmation text/e-mail system or phone call.) In the event that an appt needs to be cancelled, please be sure to speak to one of our team members via phone call. It is your responsibility to let us know. If your appointment is not confirmed, we may give your appointment away to another patient in need. This will be considered a broken appointment.

_____ _____

Patient Signature Date

# Smile Naples Missed Appointment Agreement

Your appointment is time we reserve specifically for you. We value you as our patient and need your cooperation with keeping appointments so that we can provide the best care. Missing or cancelling an appointment with short notice means we are unable to fill this appointment time with another patient who needs care.

Our policy requires:

- Appointment Confirmation: You must confirm your appointment at least 24 hours before your appointment time. (Either by our confirmation text/e-mail system or phone call.) It is your responsibility to let us know. If you do not call to confirm we may give your appointment away to another patient in need. <u>This will be considered a missed appointment.</u>

  Initials _____

- Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. <u>Cancellations made with less than 24 hours' notice will be considered a missed appointment and may incur a fee.</u>

  Initials _____

- On Time Arrivals: If you are more than 15 minutes late to your appointment, we may give your appointment away to another patient in need. <u>This will be considered a missed appointment.</u>

  Initials _____

- Compliance: Patients are only allowed ONE missed appointment in a 12 month period. After the second missed appointment, you will incur a fee.

  Initials _____

Many patients use Smile Naples' services. Your help in keeping your appointments enables us to provide better and timelier care for all our patients.

_____ _____

Patient or Parent/Guardian Signature Date

# 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/15, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

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## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

## Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

## Your Health Information Rights

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (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. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach**. You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

## 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 if 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.

**Our Privacy Official**: Danielle Gravina

Telephone: (239) 598-4333
Fax: (239)598-9743
Address: 2388 Immokalee Rd.

E-mail: info@smilenaples.com