Dental Studio
OF PALM HARBOR

Welcome to Our Practice!

We are so pleased to welcome you to our Dental Family. Our goal is to provide you with the highest quality dental care in a friendly, comfortable, and compassionate environment. We are dedicated to helping you achieve optimal oral health and a beautiful smile. Thank you for trusting us with your dental care!

New Patient Information Form

---

1. Personal Information

- **Full Name**: _____
- **Date of Birth**: _____
- **Gender**: ☐ Male ☐ Female ☐ Other: _____
- **Address**: _____
  - City: _____ State: _____ ZIP: _____
- **Phone Number**: _____
  - (Home) _____ (Cell) _____
- **Email Address**: _____
- **Preferred Method of Contact**: ☐ Phone ☐ Email ☐ Text
- **Emergency Contact**: _____
- **Relationship**: _____
- **Emergency Phone**: _____

---

2. Insurance Information (If Applicable)

- **Insurance Provider**: _____
- **Policy/ID Number**: _____
- **Group Number**: _____
- **Primary Policyholder's Name**: _____
- **Relationship to Patient**: _____
- **Secondary Insurance (if applicable)**: _____
- **Policy Number**: _____

3. Health History

- **Primary Care Physician:** _____
- **Phone Number:** _____
- **Have you had any of the following conditions? (Check all that apply)**
  - ☐ Heart Disease
  - ☐ High Blood Pressure
  - ☐ Diabetes
  - ☐ Asthma
  - ☐ Allergies (Please list): _____
  - ☐ Blood Disorders
  - ☐ Pregnancy (Current or Recent)
  - ☐ Anemia
  - ☐ Anxiety
  - ☐ Fainting
  - ☐ Hepatitis A
  - ☐ Hepatitus C
  - ☐ Kidney Disease
  - ☐ Liver Disease
  - ☐ Pacemaker
  - ☐ Radiation (Head/Neck)
  - ☐ Rheumatic Fever
  - ☐ Stroke
  - ☐ Thyroid Disease
  - ☐ Artifical Heart Valve
  - ☐ Artificial Joints
  - ☐ Bisphosphates
  - ☐ Blood Thinners
  - ☐ Cancer/ Chemotherapy
  - ☐ Cholesterol
  - ☐ Drug Addiction
  - ☐ Heart Murmur
  - ☐ Hepatitus B
  - ☐ HIV Positive/ AIDS
  - ☐ Latex Allergy
  - ☐ Nervousness/ Depression
  - ☐ Psychiatric Treatment
  - ☐ Respiratory Problems
  - ☐ Seizures
  - ☐ Stomach Problems
  - ☐ Low Blood Pressure
  - ☐ Other: _____

- **Are you currently taking any medications?**
  ☐ Yes ☐ No
  If yes, please list: _____

- **Do you have any drug allergies?**
  ☐ Yes ☐ No
  If yes, please specify: _____

Patient Signature or Parent of Child Signature: _____

Date: _____

4. Dental History

- **Date of Last Dental Visit**: _____
- **Reason for Your Visit**: _____
- **Have you had any of the following? (Check all that apply)**
  - ☐ Cavities
  - ☐ Gum Disease
  - ☐ Tooth Sensitivity
  - ☐ Oral Surgery
  - ☐ Braces
  - ☐ Nightguards
  - ☐ Other Dental Treatments: _____
- **Do you smoke or use tobacco products?** ☐ Yes ☐ No
- **Do you drink alcohol? If yes, how many drinks per week?** _____

5. Consent and Acknowledgment

- **I hereby authorize the release of any medical or dental information necessary for the processing of insurance claims.**
- **I acknowledge that the information provided above is accurate to the best of my knowledge and understand that providing false information can affect the quality of care I receive.**
- **I consent to dental treatment as recommended by the dentist after discussing any alternatives and potential risks.**

Signature: _____ **Date:**_____

HIPPA:

Authorization to Release Information

I hereby authorize The Dental Studio of Palm Harbor to discuss my protected health information the following person(s):

Name:_____ **Relationship:** _____

Name:_____ **Relationship:** _____

OR ☐ I decline. Please do not discuss my care with anyone other than allowed by HIPPA regulations.

6. Financial Responsibility

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

CREDIT CARD PROCESSING FEE :

To keep our fees accessible for all of our patients, we apply a 3% service charge only to credit card payments, as credit card companies charge us a processing fee on each transaction. There is no additional fee when you pay by debit card, check, or cash. This allows us to keep our overall costs as low as possible, while still offering convenient payment options.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $40.00. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient Signature or Parent of Child Signature: _____

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 3438 Tampa Rd. Palm Harbor, FL, 34684

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient Signature or Parent of Child: _____

General Consent Form

Medical History Information

Please understand that it is important you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any drug allergy you have.

_____**(Patient Initials)**

Restorations

I understand that care must be exercised in chewing on fillings until directed by doctor or staff to avoid breakage of soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that sensitivity may occur after a newly placed filling.

_____**(Patient Initials)**

Changes In Treatment

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary after consultation.

_____**(Patient Initials)**

Complications

Complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness, and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscular cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). [It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe.] [Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.]

_____**(Patient Initials)**

X-rays and Photos

Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office x-rays panoramic x-rays to allow us to do a throughout exam for each patient. Patients will receive a full mouth series of inra-oral x-rays. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw.

_____**(Patient Initials)**