Orange Blossom Dentistry
Patient Registration Form

Patient information:

First name: _____ MI:____ Last Name:_____

Address: _____ City:_____ State/Zip: _____

Home Ph:_____ Work Ph:_____Cell Ph:_____

Birth Date:_____ Age:_____ Sex:____ Marital Status:_S _M _W _ D

Social Security #:_____ Driver's License #:_____State:____

Email Address:_____

Emergency Contact:_____ Relationship:_____Ph#:_____

Previous Dentist:_____

Dental Insurance:

Policy Holder's Full Name:_____

Relationship to Patient:_____ Policy Holder's Phone #:_____

Policy Holder's Birth Date:_____ Policy Holder's Employer:_____

Insurance Company:_____ Group #:_____

Policy ID #:_____ Policy Holder Social Security #:_____

Responsible Party (if different from patient):

First Name:_____ MI:_____ Last Name:_____

Address:_____ City:_____ State/Zip:_____

Home Ph #:_____ Work Ph#:_____ Cell Ph#:_____

Birth Date:_____ Social Security #:_____ DL #:_____

How did you hear about our office? Please let us know!

___Newspaper ___Location/Sign ___Insurance Company ___Mailer ___Facebook

___Internet Search: Google? ___ Yelp? ___ Other? ___

___ Care Credit ___ Marketing Event

If you were referred to our practice by a friend, family member, or another doctor please let us know so we can thank them:

_____

Medical History

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No Preferred Pharmacy:
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

*This form will be updated yearly even if NO changes

Orange Blossom
Dentistry

Smile Evaluation

- How long has it been since you were seen by a dentist? ____6 months ____1-2 years___3-5 years ___5+years
- What is your main concern today? _____Broken/Cracked Teeth ____ Cavities/Decay ____Cosmetic Dentistr

  ____Cleaning ____Missing Teeth/Implants ____ Gum Disease ____Orthodontics ___Dentures ____Whitening

  Other, Please List: _____
- ____Tooth Pain ____Sensitivity

  Areas experiencing this: ___ Upper Right ___ Upper Left ___ Lower Left ___ Lower Right

  Explain Pain or Sensitivity: ___ Throbbing/Pulsating ____ Dull/Constant Ache ___ When Brushing/Flossing

  ___ When Drinking Cold Drinks ___ When Drinking Hot Drinks ___ When Chewing
- If our doctor finds an issue that should be addressed immediately, are you interested in having treatment done today? ____ Yes ____ No
- Do you have any anxiety, fear or bad experiences associated with dental offices? ___ Yes ___ No

  If yes, would you say that you have ___ Low Anxiety ___ Moderate Anxiety ___ High Anxiety
- Do you like the appearance of your smile and look of your teeth? ___ Yes ___ No

  If no, what would you like to change about your smile? _____
- What is most important to you when seeking dental treatment? ___ Quality of Service ___ Friendliness of staff

  ___Technology ___ Comfort ___ Cost ___Convenient Office Hours ___Cleanliness of Office
- Are you aware of clenching/grinding your teeth? ___Yes ___ No
- Have you ever had periodontal gum treatment (deep cleaning, surgery or gum grafting)? ___Yes ___ No
- Have you ever had orthodontic treatment (braces)? ___Yes ___ No
- Have you had your wisdom teeth removed? ___ Yes ___ No
- How many times a day do you brush? _____ How many times a week do you floss? _____
- Are you concerned about bad breath? ___ Yes ___ No
- May we take the necessary dental x-rays in order to provide you with an accurate diagnosis? ___ Yes ___ No
- Is there anything else you would like us to know about you?

_____

_____

Orange Blossom Dentistry

No Show, Missed Appointment Office Policy

When our office schedules your appointment, we are setting aside a dedicated chair and time slot just for YOU. We only ask that if you must reschedule your appointment, please provide us with a minimum 24-hour notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

There is a charge of $50.00 per hour for not showing up for a scheduled appointment.

Repeated cancellations or missed appointments will result in loss of future appointment privileges without pre-paying the full amount of the scheduled procedure to reserve your appointment time

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt as well.

I, _____ (print name), understand and consent to Orange Blossom Dentistry's Appointment Cancelation Policy.

X_____

Signature of the patient/parent **Date**

Orange Blossom Dentistry

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Please read this document thoroughly and sign the bottom acknowledging that you have read and understand this document.

Financial Guidelines: We provide a complimentary insurance benefit check for patients who have dental insurance to better understand your coverage. *It is ultimately your responsibility to be aware of your own coverage and to provide us with as much information as possible*. We accept assignment of benefits paid directly to our office by your insurer. *We will estimate as closely as possible how much your insurance will cover, but these are estimates and actual coverage amounts and the amounts you owe may differ.* You are ultimately responsible for all charges incurred. We collect estimated copayments and deductibles on the day services are rendered. A $25 fee will be assessed on all insufficient fund payments.

After 60 days, you are responsible for paying the balance on the account in full if your insurance company has not paid and a $5.00 rebilling fee will be assessed if a third billing statement needs to be sent. After 90 days without payment, a finance charge may be added to your account and/or your account may be turned over to a collection agency.

Patients without insurance are expected to pay in full by cash or credit card on the day services are rendered, unless a financial agreement has been made before beginning treatment. For your convenience, we offer Care Credit to finance your dental needs.

Here is some important information about insurance benefits:

- Your dental benefits are based upon a contract made between your employer and insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly.

- Insurance companies do not recognize many routine and newer dental services. Our team will gladly fill out the necessary forms to maximize your dental benefits and discuss your financial options. Superior dental care is rendered with or without dental benefits.

- Our office participates with several PPO insurance companies and will work with other PPO plans. You will be surprised to know that the average dental benefit plan today has a yearly cap of $1,000.

- Dental benefit plans are designed to assist you in paying for care, not to completely cover all of it.

- Most private dental offices will have fees that insurance companies define as "higher than usual and customary".

By signing below, I understand and agree to the above guidelines for the office

Signature:_____

Date:_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **Client's name:** _____
   First Name Middle Name Last Name

2. **Date of Birth:** ___/___/___ 3. **SSN:** ___-___-___ 4. **Date authorization initiated:** ___/___/___

5. **Authorization initiated by:** _____
   Name (client or provider) (If provider, please specify relationship to client)

6. **Information to be Used or Disclosed:**
   - ☐ My dental information relating to the following treatment or condition: _____
   - ☐ Most recent ____ years of record
   - ☐ My dental records for the following date(s): _____
   - ☐ Entire dental record
     - ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse
     - ☐ Include ☐ Exclude: My health information related to HIV/AIDS
   - ☐ Other information to be used or disclose (describe information in detail): _____
     _____
     _____

7. **Purpose of Use or Disclosure:**
   - ☐ Treatment, Payment or Health Care Operations
   - ☐ Disclosure to Life Insurer for Coverage Purposes
   - ☐ Disclosure to Employer of results of pre-employment physical or lab tests
   - ☐ Marketing Purposes
   - ☐ To the Following Family Members: _____
   - ☐ Other (describe each purpose of the requested use and disclosure in detail): _____
     _____
     _____

8. **Person(s) Authorized to Make the Disclosure:** _____

9. **Person(s) Authorized to Receive the Disclosure:** _____

10. **This Authorization will:** ☐ **not expire,** ☐ **expire on** ___/___/___ ☐ **or upon the happening of the following event:** _____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of the Client: _____

Signature of Personal Representative: _____

Relationship to Client if Personal Representative: _____

Date of 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 provider at the following address (insert address of provider):

   _____

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 my 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 separate 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 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.