~ Welcome to Caring Way Dentistry ~

In an effort to provide the best service possible please complete this form.

PERSONAL INFORMATION

Patient Name: ____ **Date:** ______________

Social Security #:____________________ **Birth date:** ______________ **Sex:** M F

Home Address: ____

City: __________________________________ **State:** _________ **Zip Code:** ____________

Home Phone: ____________________________ **Cell Phone:** ____________________________

Emergency Contact: ________________________ **Phone:** _______________________________

Email Address: ____

Marital Status: ◻ Single ◻ Married ◻ Divorced ◻ Other

DENTAL INSURANCE

(PLEASE PROVIDE INSURANCE CARD IF POSSIBLE)

Policy Holders Name: _____________________**Policy Holders Social Security #:**________________

Policy Owners Birthdate: __________________ **Relationship to Patient:** _________________________

Employer Name: ___________________ **Insurance Company Name:** ________________________

Phone Number: ______________________ **Insurance Company Address:** _____________________

Subscriber #: __________________________ **Group Number:** ______________________________

DENTAL HISTORY

Date of last dental visit: ______________________ **Date of Last X-Rays:** _____________________

How often do you floss? _______________________ **How often do you brush?** _________________

Reason for your visit today: ____

Please check all that apply: ◻ Loose teeth/ Fillings ◻ Bad Breath ◻ Grinding Teeth ◻ Bleeding Gums ◻ Frequent Headaches ◻ Lip or Cheek Biting ◻ Jaw Clicking/ Pain ◻ Periodontal Treatment ◻ Tooth Pain ◻ Sleep Apnea ◻ Jaw, Head, or Neck Injuries__________________________________

Sensitivity To: ◻Cold ◻Hot ◻Sweets ◻Biting

Do you have or have had any of the following: ◻ Dentures ◻ Partial Dentures ◻ Orthodontic Retainer ◻ Dental Implants ◻ Night Guard ◻ Braces ◻ Invisalign

SMILE Questionnaire

Please circle YES or NO to the following questions:

	YES	NO
Are you happy with your facial appearance? (i.e. wrinkles, fine lines, age spots, veins)	☐	☐
Do you snore?	☐	☐
Do you have trouble breathing?	☐	☐
Have you ever been diagnosed with sleep apnea/ OSAS/ and or UARS?	☐	☐
Do you have jaw pain?	☐	☐
Are you nervous and or anxious for/ during dental appointments?	☐	☐
Do you wish to discuss oral sedation?	☐	☐
Are interested in changing your smile?	☐	☐

If so, what would you like to change about your smile?

☐ Whiter teeth ☐ Straighter Teeth ☐ Replace Missing Teeth

☐ Misshapen Teeth ☐ Healthy teeth ☐ Gaps and or Spaces

Please circle what your personal desires are on the following spectrum:

I will do whatever to keep my teeth	☐ - ☐ - ☐ - ☐ - ☐	I am indifferent about keeping my teeth.
I consider dental care a high priority	☐ - ☐ - ☐ - ☐ - ☐	I consider dental care a low priority
I will do whatever I must to keep my teeth	☐ - ☐ - ☐ - ☐ - ☐	I would generally prefer short-term solutions to lower initial costs
My dental insurance will largely determine the extent of my care	☐ - ☐ - ☐ - ☐ - ☐	I will determine the extent of care based on my best interests

When discussing your oral health, how would you like the information presented to you?

☐ Big Picture ☐ Some Details ☐ I want to know everything

MEDICAL HISTORY

Please answer YES or NO to the following questions?	YES	NO
Are you currently under medical care now?	□	□
Have you ever been hospitalized or had a major operation	□	□
If yes: ____		
Have you Ever Taken Bisphosphonate Drugs?		
(Fosamax, Boniva, Zometa, Aredia, Actonel, Reclast, Prolia)	□	□
Do you smoke, chew tobacco, or vape?	□	□
Are you currently pregnant?	□	□

Please List ALL Medications you are currently taking: (Include all Vitamins, Herbs and OTC Medications: ____

____

Please check all that apply.

- □ **Acid Reflux**
- □ **Anxiety**
- □ **Artificial Heart Valve**
- □ **Artificial Joint or Implant**
- □ **AIDS/ HIV**
- □ **Allergies – (Seasonal)**
- □ **Asthma**
- □ **Blood Disorder**
- □ **Cancer**
- □ **Cardiovascular Disease**
- □ **Chemotherapy**
- □ **Chemical Dependency**
- □ **Circulatory Problems**
- □ **COPD**
- □ **Diabetes**
- □ **Emphysema**
- □ **Epilepsy/ Seizures**
- □ **Fainting Spells/ Dizziness**
- □ **Gerd**
- □ **Glaucoma**
- □ **Headaches /Migraines**
- □ **Hearing Disorder**
- □ **Heart Murmur**
- □ **Heart Attach/ Failure**
- □ **Heart Problems/ Disease**
- □ **Heart Pacemaker**
- □ **High Blood Pressure**
- □ **Hypoglycemia**
- □ **Irregular Heartbeat**
- □ **Liver Disease**
- □ **Low Blood Pressure**
- □ **Mitral Valve Prolapse**
- □ **Organ Transplant**
- □ **Osteoporosis**
- □ **Psychiatric Care**
- □ **Radiation Therapy**
- □ **Respiratory Problems**
- □ **Rheumatic Fever**
- □ **Shortness of Breath**
- □ **Stomach/ Intestinal Issues**
- □ **Stroke**
- □ **Swelling of Limbs**
- □ **Swollen Neck Gland(s)**
- □ **Thyroid Disease**
- □ **Tuberculosis**
- □ **Ulcers**
- □ **Vertigo**
- □ **Other** ________________

____

____

____

<u>Allergies</u> (CHECK all that apply) □**Aspirin** □**Codeine** □**Erythromycin** □**Keflex**
□**Latex** □**Metals** □ **Penicillin** □**Sulfa** □**Tetracycline** □ **Other**__________________

To the best of my knowledge I have answered all the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health and will inform the office of any and all updates and or changes in my medical status.

Patient Signature: ____________________________________**Date:**________________________

Guardian Signature (if patient is a minor):____

FINANCIAL POLICY

Thank you for choosing Caring Way Dentistry as your dental provider. Dr. Villescas and the entire team believe in providing you with the best dental care and want you to feel as comfortable as possible throughout your treatment. This includes understanding your prescribed treatment as well as our financial policy.

Payment is due in full at the time of service(s).
We accept cash, check, Visa, Master Card, Discover, and American Express. We also offer extended credit payment options with prior credit approval through third party financing companies. *Any returned checks are subject to additional fees.*

Dental Insurance.
As a courtesy to you, we will electronically bill your dental insurance company, however the payment responsibility remains with you. The amount of coverage your insurance plan provides for dental services may be limited by your insurance company by what is called “usual, customary and reasonable” (UCR) fees. Our practice is committed to providing the best dental treatment to all our patients and our fees may be different than your dental insurance company. We feel it is important to remember that your insurance policy is a contract between your insurance company and you, not our office.

Broken Appointment Fee
A fee of $50 is charged for missed or broken appointments that occur with less than 24-hour advance notice. Your appointment time is exclusively reserved for you and to best serve you, please keep your scheduled appointments.

I, ____ have read and agree to this financial policy.
(Printed Patient Name)

X____ ____________________
Patient Signature Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease The practice may condition receipt of treatment upon execution of this consent

Print Name:____

Signature:____ Date: ______________________________

May we phone, email or send a text to you to confirm appointments? YES NO

If yes, please provide email address: ____

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your dental conditions with any member of your family? YES NO

If YES, please name the family members allowed:

____

____

FOR 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:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Signature of Staff Member: ____ Date: _________________________

HIPAA 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 11/15/2023, 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.

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:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o 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: STACY/ Telephone: 941-627-9900 / Fax: 941-627-2629
Address: 2496 CARING WAY, PORT CHARLOTTE, FL 33952 / E-mail:
INFO@CARINGWAYDENTISTRY.COM

Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association. **This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.**
© 2010, 2013 American Dental Association. All Rights Reserved.