FAMILY SMILES OF FLEMING ISLAND

Patient Registration Form

Today's Date: _____

Title: Dr. Mr. Mrs. Ms. Miss

First: _____ Middle: _____ Last: _____

Street: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

May we contact you by email? YES NO May we contact you by text? YES NO

Sex: M F Date of Birth: _____ Social Security #: _____

Marital Status: S M D Spouse's Name: _____

Whom may we thank for referring you? _____

How did you hear about us? Please circle / check all that apply:

Mailer Google Friends/Family Insurance Internet Yellow Pages Other: _____

INSURANCE INFORMATION: Do you have Dental Insurance? Yes No

PRIMARY INSURANCE

Subscriber Name: _____ Employer Name: _____

Subscriber ID/SSN: _____ Employer Phone#: _____

Date of Birth: _____ Insurance Company: _____

Relation to Subscriber: Self Spouse Child Other Insurance Group #: _____

Insurance Phone #: _____

SECONDARY INSURANCE

Subscriber Name: _____ Employer Name: _____

Subscriber ID/SSN: _____ Employer Phone#: _____

Date of Birth: _____ Insurance Company: _____

Relation to Subscriber: Self Spouse Child Other Insurance Group #: _____

Insurance Phone #: _____

Please present your Insurance Card/s and Driver's License to the business team to be scanned.

I, hereby by virtue of my signature below, give my consent to allow this office and staff to leave messages and speak to person(s) listed regarding scheduling, treatment, and financials or other information as necessary.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If the patient is under the care of a facility and it is listed, consent will apply for all staff of the facility.

_____ I do not consent to a message being left at home, work or with any other person. I wish to be contacted directly.

I, hereby by virtue of my signature below, attest that all information provided on this "Patient Registration Form" is correct.

Patient Name: _____ Date: _____

Signature: _____

FAMILY SMILES OF FLEMING ISLAND

Patient Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our "Patient Financial Policy," which we require that you read, agree to, and sign prior to any treatment.

1. Before treatment is performed, we will discuss treatment and financial options. This will help you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.
2. Payment is due at the time service is provided.
3. Treatment Plans may change, but you are responsible for the work actually done.
4. Lab fees associated with your treatment are due prior to our submitting the case to the dental lab.
5. Our office accepts:

- Cash
- Personal Checks (Additional fees will be applied for returned checks)
- Visa, MasterCard, Discover, and American Express
- Third-party financing such as CareCredit is available upon request and approval

6. All account balances over 90-days are subject to a $35.00 late fee.
7. If sent to Collections due to non-payment, you will be responsible for related fees and court costs.

DENTAL INSURANCE: As a courtesy to you, we will help you process all of your dental 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. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums which are your responsibility. Please contact your insurance company for details of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons specifically related to your plan.

• 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 as our patient and not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

• 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.

• We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form allows us to release your treatment information to your insurance company and instructs your insurance company to make payment directly to our office.

By signing this "Patient Financial Policy," you authorize the release of any information concerning your (or your child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

• We ask that you pay the deductible, co-payment, and co-insurance which is the estimated amount not covered by your dental insurance company at the time we provide the service to you.

• Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact them to make sure payment is being processed. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

• We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

EMERGENCY CLIENTS: Emergency clients that are new to our practice are expected to make payment at the time of service.

MINORS ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN: The parent or legal guardian whether accompanying a minor or not, who has consented to treatment, is responsible for full payment at the time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

MISSED APPOINTMENT(S) & CANCELLATIONS: Our goal is to provide treatment in a timely manner with as few visits as necessary. To provide the best services to our patients, we require at least a 24-hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

CONSENT: I have read, understand, and agree to the above terms and conditions. I authorize my dental insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine and due at the time services are rendered.

COMMUNICATIONS WITH YOU: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patient Name: _____ Date: _____

Signature: _____

FAMILY SMILES OF FLEMING ISLAND

Medical History

Date: _____ Last Name: _____ First Name: _____

Birthdate: _____ Patient's BP: _____ Patient's Temp: _____

Physician's Name: _____ Physician's Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Y	N		Y	N	
☐	☐	Are you under the care of a physician?	☐	☐	Do you use tobacco?
☐	☐	Any hospitalizations or major operations?	☐	☐	Do you use recreational drugs?
☐	☐	Are you taking medications / pills?			WOMEN ONLY:
☐	☐	Have you taken bisphosphonates for osteoporosis?	☐	☐	Are you pregnant or trying to get pregnant?
☐	☐	Have you taken Phen-Fen or Redux?	☐	☐	Do you take oral contraceptives?
☐	☐	Are you taking a blood thinner?	☐	☐	Are you nursing?

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Metal	Y	N	Codeine	Y	N	Latex	Y	N	Local Anesthetics
Y	N	Acrylic	Y	N	Sulfa Drugs	Y	N	Penicillin	Y	N	Other			

If yes, please explain: _____

Do you have, or have you had, any of the following? Check each box seperately.

Y	N		Y	N	
☐	☐	Allergies, Hives, or Rash	☐	☐	Heart Attack/Failure
☐	☐	Sickle Cell Disease	☐	☐	Parathyroid Disease
☐	☐	Artificial Heart Valve	☐	☐	Tumors or Growths
☐	☐	Excessive Bleeding	☐	☐	Cold Sores/Fever Blisters
☐	☐	Hypoglycemia	☐	☐	Heart Murmur
☐	☐	Sinus Trouble	☐	☐	Psychiatric Care
☐	☐	Artificial Joint(s)	☐	☐	Ulcers
☐	☐	Excessive Thirst	☐	☐	Venereal Disease
☐	☐	Irregular Heartbeat	☐	☐	Congenital Heart Disorder
☐	☐	Spina Bifida	☐	☐	Heart Pacemaker
☐	☐	Asthma	☐	☐	Heart Problems or Surgery
☐	☐	Fainting Spells/Dizziness	☐	☐	Convulsions
☐	☐	Kidney Problems	☐	☐	Radiation Treatments
☐	☐	Stomach/Intestinal Disease	☐	☐	Recent Weight Loss
☐	☐	Blood Disease	☐	☐	Yellow Jaundice
☐	☐	Frequent or Chronic Cough	☐	☐	Arteriosclerosis
☐	☐	Shingles	☐	☐	Tonsillitis
☐	☐	Emphysema	☐	☐	Chemotherapy
☐	☐	High Blood Pressure	☐	☐	Hay Fever
☐	☐	Angina Pectoris	☐	☐	Pain in Jaw Joint(s)
☐	☐	Arthritis / Gout	☐	☐	Tuberculosis
☐	☐	Epilepsy or Seizures	☐	☐	Chest Pains
☐	☐	Easily Winded	☐	☐	Cancer
☐	☐	Herpes	☐	☐	Glaucoma
☐	☐	Scarlet Fever	☐	☐	Mitral Valve Prolapse

Y	N		Y	N	
☐	☐	AIDS/HIV Positive	☐	☐	Leukemia
☐	☐	Cortisone Medication	☐	☐	Blood Transfusion
☐	☐	Hemophilia	☐	☐	Frequent Diarrhea
☐	☐	Renal Dialysis	☐	☐	Liver Disease
☐	☐	Alzheimers's Disease	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Lung Disease
☐	☐	Hepatits A	☐	☐	Frequent Headaches
☐	☐	Rheumatic Fever	☐	☐	Low Blood Pressure
☐	☐	Anaphylaxis	☐	☐	Swelling of Limbs
☐	☐	Drug Addiction	☐	☐	Bruise Easily
☐	☐	Hepatitis B & C	☐	☐	Genital Herpes
☐	☐	Rheumatism	☐	☐	Thyroid Disease/Problems
☐	☐	Anemia			

Have you ever had any serious illness not listed above? Y N If yes, please explain:

_____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

Y	N		Y	N	
☐	☐	Are you on a special diet?	☐	☐	Immunosuppressed?
☐	☐	Have you had Orthopedic Surgery?	☐	☐	Gained or lost more than 10lbs in past year?
☐	☐	Are you experiencing discomfort at this time?	☐	☐	Have you had Cosmetic Surgery?
☐	☐	History of head/neck radiation treatment?	☐	☐	Have you had a head or neck injury?
☐	☐	Do you ever wake up short of breath?	☐	☐	Do you use two pillows to sleep?
☐	☐	Admitted to a hospital in last 2 years? What for?			

I understand that the above information is necessary to provide dental care in a safe and efficient manner. I have accurately answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to me (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

I, hereby, authorize the dentist and team to take x-rays, study models, photographs, or use any other diagnostic aid as deemed appropriate by the dentist to make a thorough diagnosis of my or the Patients' dental needs. I also authorize the dentist to perform and use any and all forms of treatment, medication, and therapy that may be indicated in connection with my dental care.

Name of Parent/Guardian If Applicable: Name of Dentist:

_____ _____

Patient Signature: Dentist Signature:

_____ _____

FAMILY SMILES OF FLEMING ISLAND

Photo and Video Consent Form

I recognize that my dentist and dental team are proud of the quality treatment that they will provide to me. I, hereby, provide my consent for dental photographs, videos or audio to be taken of me and/or my dependent(s) for dental treatment. I understand that the information may be used for the following purposes:

- Dental records and research
- Dental education including lectures, seminars, demonstrations, professional publications such as journals or textbooks
- Dental office marketing materials and advertisements including websites, social media platforms, and printed materials and patient education

By consenting to release my dental photographs, videos or audio I understand that I will not receive payment from any party. Although these materials will be used without identifying information, I understand that it is possible that someone may recognize me. Refusal to consent to dental photographs or videos or audio will in no way affect the dental care that I will receive.

I authorize the use of these images (Please check / circle the YES or NO boxes below):

YES NO For demonstration purposes including an office photo album
YES NO For office website, professional journal and/or advertisement purposes or social media accounts such as: Facebook, Instagram, Twitter, etc.
YES NO I give my consent for ONLY non-identifying photos to be used

By signing below, I confirm that I understand this "Photo and Video Consent Form" completely and that my questions, if any, have been asked and answered.

Patient Name: _____ Date: _____

Signature: _____

FAMILY SMILES OF FLEMING ISLAND

HIPAA - Notice of Privacy Policy

Effective Date: December 8th, 2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you pursuant to the "Health Insurance Portability and Accessibility Act" of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

1. Your Rights:

• You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

• You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

• You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

• You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

• You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

• You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at lisa.woodman@adentalpartners.com.

2. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

• We may provide your Health Information to other health care professionals – including doctors, nurses, and technicians – for purposes of providing you with care.

• Our billing department may access your information – and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

• We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

3. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

• To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

• For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification, and other proceedings.

• In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

• To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

• For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

• For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

4. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

• Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.

• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization.

• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

• Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our “Do Not File Insurance Form”.

5. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

• Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

• Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

• Electronic Exchange. Your information may be shared with other providers or labs through our EMR/EHR system(s) or to Insurance Companies via Renaissance Systems and Services.

6. Our Duties:

• We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

• We are also required to abide by the terms of this Notice.

• We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information – even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

7. Complaints to our Practice and the Government:

• You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services (“DHHS”) if you believe your rights have been violated.

• We will review all complaints in a professional manner and keep you informed of your rights as our patient.

• We promise not to retaliate against you for any complaint you make about our privacy practices.

8. Contact Information:

• You may contact us about our privacy practices or file a complaint by calling our HIPAA Privacy Officer: Lisa Woodman at 941-228-9732 or emailing lisa.woodman@adentalpartners.com.

• You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257 Toll Free: 1-877-696-6775

Dental Group Associates of Florida values you and your privacy is important to us.

FAMILY SMILES OF FLEMING ISLAND

Acknowledgement of Notice of Privacy Policy

Effective Date: December 8th, 2019

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began April 14th, 2003. Many of the policies have been our practice for years. This form is a "friendly" version, a more complete text is posted in the office.

Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. We balance your privacy with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at: www.hhs.gov

You acknowledge the following policies that have been adopted by Dental Group Associates of Florida, P.A.:

1. You understand that all patient information will be kept confidential except as is necessary to provide service or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA via a Business Associates Agreement.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the Practice Administrator or the Doctor.

6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You may have the right to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, hereby acknowledge my agreement with my signature below to the terms set forth in the HIPAA Notice of Privacy Practices which has been provided to me for review and any subsequent changes in the offices

Patient Name: _____ Date: _____

Signature: _____