Welcome

CONFIDENTIAL

PATIENT INFORMATION

Date ______________________________

SS/HIC/Patient ID # ______________________________

Patient Name ______________________________
Last Name

____
First Name Middle Initial

Address ______________________________

E-mail ______________________________

City ______________________________

State ______________ Zip ______________

Sex ☐ M ☐ F Birthdate ______________ Age ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ________ years

Patient Employer/School ______________________________

Occupation ______________________________

Employer/School Address ______________________________

____

Employer/School Phone (_____) ______________________________

Spouse's Name ______________________________

Birthdate ______________________________

SS# ______________________________

Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________________

DENTAL INSURANCE

Who is responsible for this account? ______________________________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________ ______________
Date Relationship to Patient

DENTAL HISTORY

Reason for today's visit ______________________________

____

Former Dentist ______________________________

City/State ______________________________

Date of last dental visit ______________________________

Date of last dental X-rays ______________________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? ______________

How often do you brush? ______________

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HEALTH HISTORY

Physician's Name ______________________ Date of last visit ______________

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type ________	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date ______________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name ______________________

Phone (_____) ______________________

ALLERGIES

☐ Aspirin

☐ Barbiturates (Sleeping pills)

☐ Codeine

☐ Iodine

☐ Latex

☐ Local Anesthetic

☐ Penicillin

☐ Sulfa

☐ Other ______________

____

PHONE NUMBERS

Home (_____) ______________ Work (_____) ______________ Ext _____ Alt. Phone (_____) ______________

Spouse's Work (_____) ______________ Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________ Relationship ______________________

Home (_____) ______________________ Work (_____) ______________________

UPDATE (To be filled in at future appointment)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ______________ If so, what? ______________________

Patient's Signature ______________________________ Date ______________

Doctor's Signature ______________________________ Date ______________

Bayside Dental Care
3440 Bayside Lakes Blvd. SE Suite #1, Palm Bay, FL 32909

Hipaa Notice of Privacy Practices

Information about you may be used and disclosed. Please review the following carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. **"Protected health information" (PHI)** is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will sign your name and indicate any changes in our records. We may also call you by name in the waiting room. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required be the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the Dr. believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office manager of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our office manager.

Please list names of person(s) you are allowing for us to disclose information to:

____

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

Signature: ______________________________________ **Date:** __________________

Bayside Dental Care
3440 Bayside Lakes Blvd Suite #1 | PALM BAY FL, 32909 | (321) 726-8884

Restorative Dentistry

Our office is dedicated to providing the highest quality in dental care possible for our patients. This includes filling cavities with **white** composite materials. **We no longer use silver (Mercury) amalgam material to fill cavities.** Placing white composite materials requires considerably more time, enhanced techniques and costly materials. White composite materials are more expensive; however, the benefits greatly outweigh the increased cost. There may be additional costs for composites since some insurance companies do not reimburse for white composite fillings at the same rate as for **silver** amalgam fillings on posterior teeth.

PLEASE READ AND INITIAL THE FOLLOWING *STRICTLY FOR INFORMATIONAL PURPOSES*

I realize that it is mandatory that **I give as accurate and complete a medical and personal history as possible, follow any and all instructions as directed, and permit prescribed diagnostic procedures.**

Initial: ___________

I understand that **sometimes it is not possible to match the color of natural teeth exactly with composite (white) materials used for filling cavities.**

Initial: ___________

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 the initial exam. Due to additional or extensive decay, a more extensive restorative procedure; than originally diagnosed may be required.**

Initial: ___________

I understand that **care must be exercised in chewing on filled teeth, especially during the first 24 hours to avoid stress.**

Initial: ___________

I understand that **any time the original tooth structure is altered; some or in rare situations significant sensitivity is a common after effect i.e. fillings.**

Initial: ___________

I have read the above information or had it read to me, and I understand my dental care options, including the risks and benefits of each alternative.

Signature: ________________________________ **Date:** ______________________

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Written Financial Policy

Thank you for choosing Bayside Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Dental treatment is an excellent investment in an individual's medical and psychological care.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card

- ***INTEREST FREE!!***
- **Allow you to pay over time**
- **No annual fees. Down-payment or pre-payment penalties**

[1]Subject to credit approval

Please note:

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Bayside Dental Care requires payment at the beginning of large treatment plans. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans requiring an hour or more, a 50% deposit; of your treatment cost is required to **reserve** your treatment appointment.

WE REQUIRE 48HOURS FOR CANCELLATIONS OR RESCHEDULING OF YOUR APPOINTMENT
*****A fee of $65 is charged for patients who miss or cancel more than 1 time in a calendar year without MORE THAN 48-hour notice.***

Bayside Dental Care charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____
Patient, Parent or Guardian Signature   Date

____
Patient Name (Please Print)

[2]However, if we do not receive payment from you or your insurance carrier within 190 days, you will be responsible for payment of your treatment fees. Failure to pay in full for treatment will result in a collection process including age appropriate penalties.