PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE ____________________

PATIENT'S NAME ____________________ DATE OF BIRTH ____________________

SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS ____________________ PHONE ____________________

PERSON RESPONSIBLE FOR THIS ACCOUNT ____________________ PHONE ____________________

ADDRESS ____________________

EMPLOYED BY ____________________ BUSINESS PHONE ____________________

BUSINESS ADDRESS ____________________ PATIENT'S SS# ____________________

DENTAL INSURANCE PLAN (IF ANY) ____________________ REFERRED BY ____________________

EMAIL ____________________

PATIENT'S NAME

DENTAL HISTORY

CHIEF ORAL COMPLAINT ____________________

DATE OF LAST DENTAL EXAM. ____________________ ANY PREVIOUS MAJOR DENTAL TREATMENT, ☐ YES ☐ NO WHEN ____________________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✔)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long ________
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush ________
- ☐ Frequency of brushing ________
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Alcohol

MEDICAL HISTORY

PHYSICIAN'S NAME ____________________ DATE OF LAST PHYSICAL EXAM. ____________________ AGE ____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✔)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Latex sensitivity
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy If so, what month ________
- ☐ Venereal disease
- ☐ Other ________

Describe any current medical treatment including drugs taken, even though not listed above ____________________

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE ____________________ DATE ____________________

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

Royal Palm Dental Associates, P.A.

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form whether electronically, on paper, or orally, be kept confidential.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.
TREATMENT means providing, coordination, or managing health care and related services by one or more healthcare providers.
PAYMENT means such activities as obtaining reimbursement for service, confirming coverage, billing or collection activities and utilization review.
HEALTH CARE OPERATION include the business of running our practice such as conducting quality assessment and improvement activities, auditing, functions, cost-management analysis and customer service.

Any other uses and disclosures will be made only with written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request.
You have the right
***To request restriction**
***To receive confidential communications**
***To access, inspect and copy your information**
***To receive and accounting of disclosures**
***To obtain a paper copy of this notice from us upon request**

For more Information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201
877-696-6775

GENERAL CONSENT FOR TREATMENT

I, ____________________________, authorize the office of Dr. David Goldberg and Dr. Ivo Moraguez, the Dental Hygenists and Dental Assistants working under the dentist's supervision to perform the following routine procedures on

____

Name of Patient

1. Restorative (fillings)
2. Periodontics (Gum Treatments)
3. Oral Surgery (Extractions)
4. Endodontics (Root Canal)
5. Prosthetics (Crowns, Fixed Bridges, Removable Dentures or Partials)
6. Radiographs (xrays)
7. Local Anesthesia
8. Any other necessary diagnostic treatment

This is a general consent and if the above treatment is necessary. We will inform you before the treatment is started.

I hereby certify that I have read and fully understand this consent form, and the reason why the above named treatment is necessary, its advantage, possible risks and complications. IE; temporary or permanent nerve damage leading to parasthesia, hemorrhaging, swelling, infection, additional pain, dry socket, hemotoma, lacerations and swelling of the lip due to numbness of the local anesthetic, allergic reactions from medication prescribed or from the local anesthetic used, sinusitis, if any, is possible.

I have been given the opportunity to ask questions and received answers to my questions or concerns.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the results of consented treatment.

FOR ALL FEMALE PATIENTS, PLEASE BE ADVISED THAT ANTIOBIOTICS WILL DECREASE THE EFFECTIVENESS OF ORAL OR IMPLANTED BIRTH CONTROL MEDICINES, SO ADDITIONAL PROTECTION IS REQUIRED TO AVOID PREGNANCY.

PATIENTS INITIALS__________

If patient is under 18 years of age, or otherwise unable to sign on behalf.

____

SIGNATURE OF PERSON AUTHORIZED TO CONSENT FOR PATIENT AND RELATIONSHIP TO PATIENT OR AUTHORITY OF CONSENT

I acknowledge that I have received written Post Operative Instructions that have been reviewed with me.

______________________________	______________________________
Signature of Patient	**Witness**

Royal Palm Dental Associates, P.A.
David Goldberg, D.D.S.
Ivo Moraguez, D.M.D.
11358 Okeechobee Blvd.
Royal Palm Beach, FL 33411
(561)790-0177

I have received a copy of Royal Palm Dental's Notice of Privacy Practice. It is my responsibility to read this information and if I have any questions I will contact the Governing Body or the Compliance Official.

______________________________ ______________________

Patient Signature **Date**

I, ______________________________ Under the HIPPA Compliance Law, give the office of Royal Palm Dental, permission to give the following person or persons, information regarding my health history, appointments, financial matters and any other matter that pertains to me. I will not hold the office of Royal Palm Dental, P.A., nor the doctors responsible for forwarding information to the person(s) listed below:

1.______________________________

2.______________________________

3.______________________________

______________________________ ______________________

Signature of Patient **Date**

______________________________ ______________________

Signature of Witness **Date**

EFFECTIVE IMMEDIATELY

AS A COURTESY TO OUR PATIENTS, WE CALL TO REMIND YOU OF YOUR APPOINTMENT, BUT IT IS ULTIMATELY YOUR RESPONSIBILITY TO REMEMBER YOUR APPOINTMENTS. THEREFORE, WE HAVE NO ALTERNATIVE BUT TO CHARGE A $40.00 BROKEN APPOINTMENT FEE WITHOUT 24 HOUR NOTICE. PLEASE REMEMBER THAT TIME HAS BEEN RESERVED FOR YOU. THANK YOU FOR YOUR UNDERSTANDING.

____

PATIENT SIGNATURE AND DATE

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WITNESS AND DATE