Patient Registration

Date: _____

First Name: _____ Last Name: _____

Please Circle:
Married Single Child Other Gender: Male Female Title: Mr. Mrs. Ms. Dr. Miss

Date of Birth: _____ Social Security: _____

Driver's License Number: _____ Occupation: _____

Home Address: _____ Work Address: _____

_____ _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

Email Address: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone: _____ Emergency Contact Alt Phone: _____

Person Responsible for Account: _____ Relationship to Patient: _____

Primary Insurance Carrier Name: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder ID Number: _____ Relationship to Patient: _____

Policy Number: _____

Secondary Insurance Carrier Name: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder ID Number: _____ Relationship to Patient: _____

Policy Number: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Primary Medical Physician: _____

Specialists Physician (Cardiologist, Endocrinologist): _____

How did you hear about us? _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization**: I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. **Effective Period**: This authorization for release of information covers the period of healthcare from:
   a. ☐ _____ to _____
   OR
   b. ☐ all past, present, and future periods.

3. **Extent of Authorization**:
   a. ☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
   OR
   b. ☐ I authorize the release of my complete health record with the exception of the following information:
      ☐ Mental Health Records
      ☐ Communicable Diseases (including HIV and AIDS)
      ☐ Alcohol/Drug Abuse Treatment
      ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, as any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

_____ _____
Printed name of patient or personal representative and his or her relationship to patient

_____
Date

Health History Form

Patient's Name (Print) _____ Date of Birth _____/_____/_____

Gender: Male / Female

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? *If yes, please specify:* _____	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? *If yes, please specify:* _____	Yes	No
Artificial joints placed anywhere in the body (heart valve, pacemaker, hip, knee)? *If yes, please specify:* _____	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Glaucoma?	Yes	No
Thyroid disease?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Stomach ulcers or colitis?	Yes	No	Diabetes?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Arthritis?	Yes	No
Do you clench or grind your teeth?	Yes	No	Significant weight loss or gain?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Mental Health Issues	Yes	No	Sinus or nasal problems?	Yes	No
Seizures or Neurological Issues	Yes	No	HIV/AIDS	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	HPV	Yes	No
Do you smoke?	Yes	No	Osteoporosis or osteopenia?	Yes	No
Drug or Alcohol Issues	Yes	No			

Any disease, chemotherapy or transplant operation? Cancer? Yes No If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

When was your last physical examination? _____

Are you under the care of a physician? Yes No Reason:_____

Have you had any surgery in the past three (3) years? Yes No Reason:_____

Have you been hospitalized in the past twelve (12) months? Yes No Reason:_____

Women Only:	Is there a possibility you are pregnant?	Yes	No	Are you taking birth control pills or hormonal replacement?	Yes	No
	Are you nursing?	Yes	No			

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No	Penicillin or other antibiotics?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No	Local Anesthesia or Epinephrine?	Yes	No
Sedatives, barbiturates?	Yes	No	Metals	Yes	No			

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

_____

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Heart drugs?	Yes	No	High blood pressure medications?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Antianxiety agents, sedative-hypnotics and antidepressants	Yes	No
Prescription pain medication?	Yes	No	Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? *If yes, list drugs used and time of use*. _____	Yes	No

Have you been told you need to **premedicate** or take antibiotics before a dental procedure? Yes No

Please list any **other medications** you have taken or are currently taking <u>not listed above</u> including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

_____

DOCTOR'S NOTES:

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No *If Yes, please explain?* _____

When was your last dental visit? _____

What was the reason for your last visit? _____

Do you wear dentures or partials?	Yes	No	Do you like your smile?	Yes	No
Have you ever had periodontal (gum) treatment?	Yes	No	Have you ever been treated for sleep apnea?	Yes	No
Have you ever had orthodontic (braces) treatment?	Yes	No	Do you have any of your x-rays or dental records?	Yes	No

Do you wish to talk to the doctor **privately** about anything? Yes No

How can we help you today? _____

Are you completing this form for another person? Yes No If yes, what is your relationship to the patient: _____

I have reviewed and understand the information on this questionnaire and certify that the information I have provided is accurate and complete. I understand that this information will be used by my dental office to help determine the appropriate and healthful dental treatment. If there are any changes in my medical status or condition, I will inform my dental office. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form. Since at each visit treatment plan will be presented and the work to be done is explained to me before treatment is begun, I give my dental office my consent to perform any needed dental treatment. I understand that I am financially responsible for all charges whether covered or denied by my insurance company. I also understand that, even with or without insurance coverage, I am responsible for any charges that are incurred for any treatment rendered.

_____ _____

Signature of patient, parent, guardian Date

_____ _____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments/Patient's Signature	Doctor's Signature

OFFICE POLICY

PATIENT PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care options.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. Richard J. Staller, P.A. d/b/a Advanced Dentistry South Florida operates a wholly owned subsidiary Advanced Dentistry South Florida Specialists, LLC. If you receive treatment by Advanced Dentistry South Florida Specialists, LLC those records will be maintained by Richard J. Staller, P.A. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We support your full access to your personal dental records. Once a written records request is received, your personal dental records will be released within 14 (fourteen) business days. Fees may be incurred to copy these records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke any actions that have already been taken which relied on this or a previously signed consent. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for in full at the time services are performed unless other arrangements are made. Deductibles and co-payments are due at the time of treatment.

We are pleased to be a provider for many insurance carriers and will work with dental insurance companies to maximize your benefits and directly bill them for reimbursement for your treatment. I authorize my insurance company to directly pay my dental office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize my dental office to release all necessary information to secure the payment of benefits. In the event your insurance company sends you a check as payment for the services provided here, by signing this form you have expressly agreed to irrevocably assign such payment(s) to Richard J. Staller, DDS PA and you further agree to immediately forward any payment(s) to Richard J. Staller DDS PA. Failure to forward a check that is intended to pay for services provided to you constitutes theft of assigned funds and is punishable by law.

I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company. I also understand that, even with or without insurance coverage, I am responsible for any charges that are incurred for any treatment rendered. If the insurance company does not pay your balance within 30 days, we will ask that you contact the carrier to help speed things up.

A fee of $100 is charged for patients who miss or cancel more than two times in one calendar year without twenty-four-hour notice during business hours. Additional fees may apply for "after hour" appointments. (See section noted After Hour Appointments). A fee of $25 will be charged for returned checks. Balances older than 90 days may be subject to additional collection fees and interest charges, you agree to reimburse the office the fees of any collection agency, which may be based on a percentage at a maximum of up to 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Payment options include: cash, check, Visa, MasterCard, Discover, and American Express in addition to financing options if qualified.

Advanced Dentistry South Florida 15340 Jog Road, Suite 100, Delray Beach FL, 33446
Phone: (561) 495-2099 Fax: (561) 258-2432 www.ad-sf.com

PATIENT CARE

We believe that an informed patient ends up as a happy patient. Many of the procedures in dentistry are complex and take multiple appointments, some of which may be lengthy in time. Also, due to the laboratory procedures involved, there may be weeks in between visits when no treatment is rendered. It is our goal to satisfy both the cosmetic and functional needs for our patients. While we will always do our best to please our patients, no one is as good as nature.

When fabricating dentures, it should be remembered that each set is different due to the ever-changing bone level and soft tissue of each patient. A wax try in (trial denture) will be made and the patient will be able to evaluate and make changes at this stage if necessary. Once accepted and completed, no changes can be made in the final denture without the patient incurring an additional fee. Also, after a period of time, it will become necessary to reline dentures to accommodate their fit.

While crown and bridge porcelain restorations most resemble natural teeth, there still may be some compromises in their fabrication. Also, during the lifetime of any restoration it may be necessary to repair or modify this restoration due to breakage or normal wear.

The utilization of gold collars or gold biting surfaces, the number of missing teeth, periodontal treatment, the incorporation of implants, and other factors may lead to compromises in case design. Therefore, ideal esthetics and function may be altered in an attempt to save a patient's teeth. Also, when removing existing crown and bridge, a treatment plan may be subject to change as it is not always possible to determine the health of a tooth under an existing crown. The utilization of a build-up material may be necessary to reconstruct a tooth during a crown appointment to gain more strength.

It should be noted that case success is dependent on many things, some of which include, patient health, patient resistance, home care and keeping up with maintenance visits. A designed hygiene recall program including examination and films must be followed and maintained. It is the responsibility of the patient if dental health is to be insured. The practice of dentistry is not an exact science and no guarantee can be made especially when dealing with healing and the other factors previously mentioned. When utilizing implants, case success is always dependent on the implant success.

It should be stated that during treatment or in the future, it may be necessary to refer a patient to other dental specialists such as an endodontist, periodontist, or oral surgeon. This additional cost is not included in our restorative fee.

AFTER HOUR APPOINTMENTS

There may be times when the office opens to accommodate patients before or after regular hours or during closed days (ie: weekends or holidays). During these times it is very important that those scheduled appointments are kept. A fee of **$100** is charged for patients who miss or cancel these appointments without twenty-four business hour notice.

EASY PAY

What is Easy Pay? Occasionally you will have obligations unbeknownst to us that have been set forth by your insurance company, leaving a balance on your account. We will always let you know if we feel a service may not be covered, however, ultimately the insurance contract is between you, your employer and your insurance company.

If we receive notice that there is a balance on your account due to insurance payment and/or missed appointments, your payment will be processed with the Easy Pay Service and you will be notified that your payment has been processed. If you request, we will also email or mail you a copy of your payment receipt.

Please complete the form below to authorize future payment of any balance on your account. Your billing information will be kept confidential and be guarded by the same patient privacy policy as all other patient information.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE OFFICE POLICIES SHOWN ABOVE.

_____ _____

NAME OF PATIENT TODAY'S DATE

_____

NAME OF GUARDIAN/RESPONSIBLE PARTY IF DIFFERENT

_____

SIGNATURE OF GUARDIAN/RESPONSIBLE PARTY

Advanced Dentistry South Florida 15340 Jog Road, Suite 100, Delray Beach FL, 33446
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REQUEST FOR RELEASE OF PATIENT RECORDS

Patient Name: _____
Patient DOB: _____

I, _____ (above listed patient/patient guardian), am requesting the release of my dental records/x-rays. By signing this release form, I am authorizing the release of dental x-rays and records relevant to dental treatment or copies of such. I also authorize the release of any relevant information to include payment history unless otherwise specified.

_____ _____
Patient/Guardian Signature Date

Please release TO FROM *(circle one)*	Please release TO FROM *(circle one)*
ADVANCED DENTISTRY SOUTH FLORIDA 15340 Jog Road, Suite 100 Delray Beach, FL 33446 Phone: 561.495.2099 Fax: 561.258.2432 Email: info@ad-sf.com *Please email in Dexis format if applicable*	Name: _____ Street Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Email: _____

Date of Last: FMX:_____ Exam:_____ PerioM:_____
BW's:_____ Prophy:_____ RPC: _____