WELCOME

Thank You for Selecting Our Dental Team.

To help us meet all your healthcare needs, please fill out this form completely (front and back) in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____

Soc. Sec. #_____ Birthdate _____ Home Phone _____

Address _____ City_____ State _____ Zip _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If Student, Name of School/College _____ City_____ State ____ ❑ Full-Time ❑ Part-Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City_____ State _____ Zip _____

Spouse or Parent's Name_____ Employer_____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency_____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Drivers License #_____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Payment in full at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer.

❑ Cash ❑ Personal Check ❑ Visa ❑ Mastercard ❑ Discover ❑ I wish to discuss the office payment policy.

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company_____ Group # _____

Do You Have Any Additional Insurance? ❑ Yes ❑ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company_____ Group # _____

Over Please

Patient Medical History

Patient Name _____

Physician _____ Office Phone _____ Date of Last Exam _____

Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (eg. Novocain)	❑	❑
Penicillin or any other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (eg. Nickel, mercury etc.)	❑	❑
Latex Rubber	❑	❑
Other _____	❑	❑
Women Only:		
Are you pregnant or think you may be pregnant?	❑	❑
Are you nursing?	❑	❑
Are you taking oral contraceptives?	❑	❑

	Yes	No
Are you under medical treatment now? If yes, please explain _____	❑	❑
Have you ever been hospitalized for any operation or serious illness within the last 5 years? If yes, please explain _____	❑	❑
Are you taking any medication(s) including non-prescription medicine? If yes, please list _____	❑	❑
Do you use tobacco?	❑	❑
Do you use controlled substances?	❑	❑

Do you have or have you ever had any of the following?

	Yes	No
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Rheumatic Fever	❑	❑
Swollen Ankles	❑	❑
Fainting/Seizures	❑	❑
Asthma	❑	❑
Low Blood Pressure	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Diabetes	❑	❑
Kidney Disease	❑	❑

	Yes	No
AIDS or HIV Infection	❑	❑
Thyroid Problem	❑	❑
Heart Disease	❑	❑
Cardiac Pacemaker	❑	❑
Heart Murmur	❑	❑
Angina	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Mitral Valve Prolapse	❑	❑
Liver Disease	❑	❑

	Yes	No
Arthritis	❑	❑
Joint Replacement or Implants	❑	❑
Hepatitis/Jaundice	❑	❑
Sexually Transmitted Disease	❑	❑
Stomach Troubles/Ulcers	❑	❑
Stroke	❑	❑
Hay Fever/Allergies	❑	❑
Tuberculosis	❑	❑
Radiation Therapy	❑	❑
Glaucoma	❑	❑
Other _____	❑	❑

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquid/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain to any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries, or jaw pain?	❑	❑
7. Do you have frequent headaches?	❑	❑
8. Do you clench or grind your teeth?	❑	❑
9. Do you bite your lips or cheeks frequently?	❑	❑
10. Have you ever had any difficult extractions in the past?	❑	❑
11. Have you ever had any prolonged bleeding following extractions?	❑	❑
12. Have you had any orthodontic treatment (braces)?	❑	❑
13. Do you wear dentures or partials? If yes, date of placement?	❑	❑
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑

15. Have you ever been treated or diagnosed with periodontal disease? If so, please explain. _____

16. What is most important to you about your dental health? _____

17. What is most important about a relationship with a dentist? _____

18. If there is anything you could change about your smile what would it be? _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

X _____ Date _____

Signature of patient (or parent if minor)

RP Dental & Implants

As your dentist, we are committed to providing you with the best possible dental care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

PAYMENT FOR SERVICES IS DUE AT THE DATE OF YOUR APPOINTMENT. We accept cash, personal checks, Visa, MasterCard, Discover and American Express. Return checks are subject to a service charge of $25.00 and you will lose your privilege to write checks in our office. Self-pay patients must pay at time of visit. No exceptions will be made.

BROKEN APPOINTMENT FEE. A $50.00 broken appointment fee will be applied to your account if you cancel an appointment without giving our office 24 notice during our working hours, which are 8:00 AM – 3:30 PM Monday thru Thursday, or if you do not come for your scheduled appointment. You must speak to an office staff member to cancel or reschedule the appointment. No exceptions will be made. PATIENT'S INITIAL _____

CHILDREN OF DIVORCED PARENTS. Payment is due at the time of service no matter who is responsible by order of divorce decree.

FINANCIAL AGREEMENT. We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. Your portion and deductible MUST be paid at the time of service. No exception will be made. We are an out of network dentist but we will file your insurance for you as a courtesy. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract, and do not acknowledge responsibility for each individual's policy. Please be aware it is **your** responsibility to know your insurance policy and benefits remaining, and with that said, it is your responsibility to inform us when your insurance has changed. If we have to re-file a claim because we were not notified, a processing fee may be incurred by you.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. We do our best to **estimate** your portion, but do understand each insurance company allows a set amount for each procedure, which we are not given when verifying insurance, we are only given the percentages. You will be responsible for any balance remaining after insurance pays. In the case of an overpayment, you may request a refund by calling our office. In the case of an underpayment, our practice will send you a bill.

We must emphasize that as your dental care provider, our relationship and concern is with you and your dental health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED**. Any balance left on your account after 60 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment on your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

If is becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collections, including attorney's fee, whether suit if filed or not.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY.

SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE OFFICE OF RP DENTAL & IMPLANTS MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION

We are required to maintain the privacy of your health information. This is not anything new for us. Due to the new government regulations we must now maintain these notices and patient signatures on file.

We are required to provide our patients with notice of legal duties and privacy practices in respect to reserve the right to change the terms of this notice and to make any new provisions effective for all protected health information we maintain. Patients will be provided a copy of this notice and any revisions.

The office of Dr. Lisa Wadsworth may use and disclose your protected health information for treatment, payment and healthcare operations.

Treatment may include:

- Providing, coordination and managing your dental healthcare
- Consultation between healthcare providers
- Referrals to other providers for treatment

For example, we may determine that you require the services of a specialist. In referring you we may share or transfer your dental and healthcare information.

Payment activities may include:

- Activities undertaken to obtain reimbursement for services provided to you
- Deterring your eligibility for insurance coverage
- Managing claims and contacting your insurance company regarding payment
- Collection activities to obtain payment for services provided to you
- Reviewing dental services and discussing with your insurance company the need for procedures
- Obtaining pre-authorization for procedures

For example, we will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis and services provided to you.

Healthcare operations may include:

- Contacting patients and providers with information about treatment available, alternatives, and recommendations
- Arranging for medical reviews, legal services and auditing functions

For example, we may use your diagnosis, treatment and outcomes to measure the quality of the services that we provide, or assess the effectiveness of your treatment when comparing patients in similar situations.
We may contact you, by telephone or mail to provide appointment reminder, or to discuss past, current or future treatment.

We may not disclose your health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be release without written permission to a parent, guardian, or legal custodian, or spouse.

- In certain circumstances we may be required to report information to legal authorities such as law enforcement officials, government agencies, and court officials. For example, we are required to report

abuse, neglect, domestic, violence, gunshot wounds, or certain physical Injuries if we suspect they occurred as a result of a crime.

- We may disclose records: In response to a written request by any federal or state agency such as management audits, financial audits, program monitoring and evaluations, facility or individual licensure or certifications.
- We may disclose records if a signed subpoena by a judge are received. The only record that cannot by disclosed is HIV test results.
- We may disclose records except HIV results to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death.

We will not make any other disclosure of your health information without your written permission.
You may revoke authorization at any time in writing.

YOU'RE RIGHT REGARDING YOUR PROTECTED HEALTH INFORMATION

1. You may request restrictions be placed on certain uses or disclosures of your health information by the OFFICE OF RP DENTAL & IMPLANTS. You must request in writing. We are not required to agree to your request, but if we do agree we must adhere to your restrictions in writing; except when your health information is needed in an emergency situation and then only to the healthcare provider treating you. A restriction does or would not apply when we are required by law to disclose certain healthcare information.
2. You have the right to review or obtain a copy of your records or disclosures of your information by our offices with exception of information compiled for civil, criminal, or administrative action or legal proceedings. We may deny any access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a fee for copying your records.
3. You may request that we send information, including billing information to you by alternative means or locations. You may also request that we not send information to a certain address or location or contact you at a specific location, such as your place of employment. This request must be in writing. We will accommodate reasonable requests by you.
4. You may request in writing for us to amend portions of your records as long as we maintain such information, under certain circumstances your request may be denied.
5. You may request in writing an accounting of all disclosures of your health information made by our office beginning with disclosures made after 4-14-03. We are not required to disclose records pursuant to a signed consent.
6. You may request and receive a paper copy of this notice, if you had previously received or agreed to receive this notice electronically.
7. Any person or patient may file a complaint with RP DENTAL & IMPLANTS and or the SECRETARY OF HEALTH AND HUMAN SERVICES if they believe their privacy rights have been violated. To file a complaint with Dr. Lisa Wadsworth please contact the Privacy Office at the following: Privacy Officer, 13940 US 441 STE 602, Lady Lake, Florida 32159.

It is the policy of RP DENTAL & IMPLANTS that no retention will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards. This Notice of Privacy Practices is effective 4-14-03.

Our Doctors and Staff have been trained on our policies and The Standards for Privacy of Individual Identifiable Health Information Final Rule 45 CFR 164.520. Our staff and Drs. have signed a Confidentiality Agreement to protect the confidentiality of all patients' health information. Training is at assignment of duties and then on a yearly basis or as changes are made.

RP DENTAL & IMPLANTS

13940 US 441, STE 602
Lady Lake, FL 32159
PH 352-750-0008: FAX 352-259-9145
Website: rpdentalimplants.com

PATIENT RECORD OF DISCLOSURE AND CONSENT

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI), The individual is also provided the right to confidential communications or that a communication of PHI be made by alternate means, such as correspondence to the individual's office instead of home.

I wish to be contacted in the following manner (check all that apply)

Home telephone___ Work telephone___ Cell phone___

OK to leave a detailed message with person or on answering machine___

Leave message with call back number only___ OK to mail home address___

OK to Mail to work address___ Do not mail any personal information___

Please list individuals we can discuss your information with (ex: treatment, treatment plans, diagnosis, billing, test results, appointments, pre-medication reminders)
Please list their relationship to you: (This includes spouses, children, guardians, parents, friends, significant others, etc/.)

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Signature:_____ Print patient name:_____
(Parent/guardian if patient is a minor)