PATIENT INFORMATION

BAY POINTE DENTAL GROUP, P.A.

Today's Date _____/_____/_____

Patient's Name _____
First MI Last

Please let us know if you have a nickname or preferred name by which you wish to be called. _____

Sex ☐ M ☐ F Date of Birth _____/_____/_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address _____
Street City State Zip

Phone # (_____) _____ (_____) _____ (_____) _____
Home # Work # Ext# Mobile #

Social Security # _____ E-mail Address _____

Are you a full time student? ☐ Yes ☐ No If yes, School Name _____

Employer _____
Name Address City State Zip

Has any member of your family been treated in our office? ☐ Yes ☐ No If so, who? _____

How did you hear about our office? _____

Contact in case of emergency _____ (_____) _____
Name Relationship Phone #

☐ Spouse *or* ☐ Parent, if minor _____ (_____) _____
Name Address Phone #

Person Responsible for Account _____
Name Relationship SS#

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's ID # _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Employer _____
Name Address City State Zip

We will need to copy your insurance card *or* please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (_____) _____ Group # _____ Local Union #, if any _____

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs.

Patient, Parent or Guardian Signature _____ Date _____/_____/_____

I understand this office may photograph my face and mouth for purpose of documentation in my patient chart. _____ (Initial)
I further grant my permission for this office to use my photographs for purposes of educating other patients, including placing them on our website.

Patient, Parent or Guardian Signature _____ Date _____/_____/_____

BAY POINTE DENTAL GROUP, P.A.

MEDICAL HISTORY

Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Are you under a physician's care now? ☐ Yes ☐ No If so, for what? _____

_____

Physician's Name _____ Phone # (_____) _____

Are you taking (or supposed to be taking) any medications, vitamins or herbal supplements? ☐ Yes ☐ No Please list below

_____

_____

_____

Are you pregnant? ☐ Yes ☐ No If yes, due date _____

Do you use tobacco in any form? ☐ Yes ☐ No _____

Have you ever taken or are you currently taking any bisphosphonates such as Zometa, Fosamax, Aredia, Actonel, Boniva Didronel, Skelid, Bonefos, or Alendronate? ☐ Yes ☐ No

Are you allergic to any medications or substances? ☐ Yes ☐ No If yes, please check boxes below.

☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine

☐ Latex or Rubber ☐ Other _____

Have you ever had a reaction or experienced complications to any dental treatment in the past? ☐ Yes ☐ No

Please check "yes" if you presently have or have had in the past any of the following conditions:

Yes		Yes		Yes	
☐	Heart Trouble/Disease	☐	Lung or Breathing Problems	☐	Severe Headaches
☐	Heart Murmur*	☐	Shortness of Breath	☐	Fainting or Dizzy Spells
☐	Irregular Heart Beat	☐	Sinus Trouble	☐	Epilepsy, Seizures or Convulsions
☐	Angina or Chest Pain	☐	Asthma	☐	Psychiatric Care
☐	Heart Attack or Failure	☐	Chronic Cough	☐	Hepatitis, Jaundice or Liver Disease
☐	Congenital Heart Disorder	☐	Emphysema	☐	Arthritis, Gout or Rheumatism
☐	Mitral Valve Prolapse*	☐	Tuberculosis (TB)	☐	Artificial Joint*
☐	Rheumatic Fever*	☐	Frequent Sore Throat	☐	Night Sweats
☐	Artificial Heart Valve*	☐	Tumor or Cancer	☐	Stomach or Intestinal Disease
☐	Heart Pacemaker*	☐	X-ray or Cobalt Treatment	☐	Thyroid Disease
☐	Heart Surgery	☐	Chemotherapy	☐	Kidney or Bladder Problems
☐	Stroke	☐	Enlarged Lymph Nodes (Glands)	☐	Renal Dialysis
☐	Aneurysm	☐	Swelling of Limbs	☐	Hypoglycemia
☐	High Blood Pressure	☐	Bruise Easily	☐	Frequent Diarrhea
☐	Low Blood Pressure	☐	HIV Positive or AIDS	☐	Glaucoma or Eye Problems
☐	Bleeding Disorder	☐	Sexually Transmitted Diseases	☐	Excessive Thirst
☐	Blood Transfusion	☐	Major surgery	☐	Diabetes

_____

Have you ever had any other disease, problem or condition not listed above? ☐ Yes ☐ No Discuss _____

_____

Do you wish to speak privately to the dentist about any problems? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature _____ Date _____

BAY POINTE
DENTAL GROUP, P.A.

7740 Point Meadows Drive
Suite #4
Jacksonville, FL 32256
(904) 645-6457

Welcome to our office!
We believe in optimum communication with our patients; therefore, we ask that you please read the following information and ask any and all questions so we may help you fully understand our financial and appointment policies.

FOR OUR PATIENTS FORTUNATE ENOUGH TO HAVE DENTAL BENEFITS:
Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. Please be aware that your coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. Please understand that any assistance concerning what or how much coverage you have, whether by phone or mail, is for reference only and should not be your only basis for proceeding with treatment. We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you. We will assist you in any way that we can (including electronic claims submission). In addition, because of the inconsistencies in secondary insurance benefits, we do not consider the secondary benefits when figuring your portion of the charges. We will file your secondary claims for you and the payments from your secondary can be assigned to you. We collect estimated portions calculated by our computer system up front; if there is any remaining balance after receiving this portion plus any portion your primary carrier pays, it will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment 90 days after the claim, the remaining balance will be due and payable by you and subject to interest charges (18% APR). Thanks for your understanding.

FINANCIAL AGREEMENT (FOR ALL PATIENTS):
Upon acceptance of treatment in this office the patient/guardian assumes financial responsibility for payment of fees. Treatment is to be paid in full when services are rendered unless other arrangements have been discussed and finalized. This may be in the form of Cash, Check, Visa, MasterCard, Discover, American Express or other outside financing. Any balances over 90 days old will be assessed a finance charge of 18% APR. In the event it should become necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including attorney's fees.

REGARDING APPOINTMENTS:
Our time is valuable and so is yours. Our commitment to you is:

- We always try to make appointments that are convenient for you.
- We will not ask you to make a schedule change unless it is an extreme emergency.
- We will always be conscious of your personal time and will try to start your dental appointments on time and complete your treatment as efficiently as possible.

Please understand that **we reserve chair time just for you** when you make an appointment with us. In an effort to continually provide quality service, we ask that you keep your reserved appointment as it is scheduled. Kindly give **48 hours (or more)** notice if you need to change your appointment. In the case of a failed appointment, you may be placed on our standby list. Our standby list patients are called if and when we get a short notice opening in our schedule.
Any failed appointment without 48 hours notice is subject to a $50 missed appointment fee.

Please keep us informed of any changes to your health information as well as your address, phone, email or insurance information so that we may serve you in the best possible manner.

I have read and understand the above financial policies. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

X _____ _____ _____
(Patient or Parent or Guardian signature) (Date) (Print patient's name)

BAY POINTE
DENTAL GROUP, P.A.

7740 Point Meadows Drive
Suite #4
Jacksonville, FL 32256
(904) 645-6457

REGARDING PATIENT PRIVACY

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Submit

Reset

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mail, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.05 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Susan Vasquez
Telephone: (904) 645-6457
Address: 7740 Point Meadows Drive, Suite #4
Jacksonville, FL 32256