WinterGarden smiles

General and Pediatric Dentistry

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is confidential.

Patient Name: _____ Date of Birth: _____ Age: _____ SSN#: _____ ❑ Female ❑ Male

Address: _____ Weight: _____ Height: _____ E-mail: _____

_____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____ Emergency Contact Number: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

## Dental Information: *For the following questions please mark (X) your response to the following questions.*

Do your gums bleed when you brush or floss?..... ❑Yes ❑No
Are your teeth sensitive to cold, hot, sweets or pressure? ❑Yes ❑No
Does food or floss catch between your teeth?..... ❑Yes ❑No
Is your mouth dry? ..... ❑Yes ❑No
Have you had any periodontal (gum) treatments? ..... ❑Yes ❑No
Have you ever had orthodontic (braces) treatment? ..... ❑Yes ❑No
Have you had any problems associated with previous dental treatments? ..... ❑Yes ❑No
If your home water supply fluoridated? ..... ❑Yes ❑No
Are you currently experiencing dental pain or discomfort? ❑Yes ❑No
What is the reason for your dental visit today?
_____

Do you have any clicking, popping, or discomfort in your jaw? ❑Yes ❑No
Do you brux or grind your teeth? ..... ❑Yes ❑No
Do you have sores or ulcers in your mouth?..... ❑Yes ❑No
Do you wear dentures or partials? ..... ❑Yes ❑No
Do you participate in active recreational activities? ..... ❑Yes ❑No
Have you ever had a serious injury to your head or mouth?..... ❑Yes ❑No
Date of your last dental exam: _____
What was done at that time?
_____
Date of last dental x-rays: _____
How do you feel about your smile?
_____

## Medical History: *For the following questions please mark (X) your response to the following questions and fill in additional information requested.*

Are you now under the care of a physician?..... ❑Yes ❑No
If yes, for what reason? _____
Physician's Name: _____
Address: _____
Phone #: _____
Are you in good health?..... ❑Yes ❑No
Date of last physical exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years?..... ❑Yes ❑No
If yes, what was the illness or problem? _____
_____
Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... ❑Yes ❑No

**Please list all prescription medications, including vitamins, natural or herbal preparations and/or diet supplements: _____
_____
_____

## Medical Information: *For the following questions please mark (X) your response to the following questions and fill in additional information requested.*

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax), risedronate (Actonel), or ibadronate (Boniva) for osteoporosis or Paget's disease? ❑Yes ❑No Date of Treatment Began: _____

Were you treated from Hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?
❑Yes ❑No Date of Treatmented Began: _____

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain.
❑Yes ❑No

Do you use tobacco products? ❑Yes ❑No
If yes, which tobacco products do you use: ❑ Cigarettes ❑ Pipe ❑ Cigars ❑ Chew
If yes, How interested are you in stopping? ❑ VERY ❑ SOMEWHAT ❑ NOT INTERESTED

Do you drink alcoholic beverages? ❑Yes ❑No If yes, how much do you typically drink in a week? _____

**Women Only:**
Are you pregnant or suspect that you may be?
❑Yes ❑No Number of weeks _____

Are you nursing? ❑Yes ❑No

## Insurance Information: *(only if you have dental insurance)*

Primary Insurance Plan Name: _____ Address: _____
Name of Insured (person): _____
_____
Is insured a patient? ❑Yes ❑No
Insured's Address: _____ Insured's Birth Date: _____ ID#: _____
_____Group #: _____
Insured's Employer Name: _____
Patient's relationship to insured: (self, child, spouse, other) _____

**Allergies/Sensitivities:** ***Check (X) all that apply or check none. Are you allergic/sensitive (or ever had an adverse reaction) to:***

❑ Local anesthetics ❑ Aspirin ❑ Penicillin or other antibiotics ❑ Barbiturates, sedatives, or sleeping pills ❑ Sulfa drugs

❑ Codeine or other narcotics ❑ Metals ❑ Latex (rubber) ❑ Iodine ❑ Hay fever/seasonal ❑ Other: _____

***Do you have, or have you ever had any of the following: Please mark (X) yes or no.***

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Abnormal Bleeding | ❑Yes | ❑No | Emphysema | ❑Yes | ❑No | Mitral Value | ❑Yes | ❑No | Difficulty Breathing | ❑Yes | ❑No |
| Alcohol Abuse | ❑Yes | ❑No | Epilepsy | ❑Yes | ❑No | Pacemaker | ❑Yes | ❑No | Liver Disease | ❑Yes | ❑No |
| Allergies | ❑Yes | ❑No | Fainting Spells | ❑Yes | ❑No | Yellow Jaundice | ❑Yes | ❑No | Diabetes | ❑Yes | ❑No |
| Anemia | ❑Yes | ❑No | Kidney Problems | ❑Yes | ❑No | Psychiatric Problems | ❑Yes | ❑No | Heart Mumur | ❑Yes | ❑No |
| Angina Pectoris | ❑Yes | ❑No | Frequent Headaches | ❑Yes | ❑No | Radiation Therapy | ❑Yes | ❑No | Sickle Cell Disease or trait | ❑Yes | ❑No |
| Arthritis | ❑Yes | ❑No | Glaucoma | ❑Yes | ❑No | Rheumatic Fever | ❑Yes | ❑No | Rheumatic Heart Disease | ❑Yes | ❑No |
| Artificial Bones | ❑Yes | ❑No | Hay Fever | ❑Yes | ❑No | Seizures | ❑Yes | ❑No | | | |
| Artificial Heart Valve | ❑Yes | ❑No | Heart Attack | ❑Yes | ❑No | Drug Abuse | ❑Yes | ❑No | | | |
| Asthma | ❑Yes | ❑No | Heart Surgery | ❑Yes | ❑No | Eye Problems | ❑Yes | ❑No | | | |
| Blood Transfusion | ❑Yes | ❑No | Hemophilia | ❑Yes | ❑No | Sinus Problem | ❑Yes | ❑No | | | |
| Cancer/Chemotherapy | ❑Yes | ❑No | Hepatitis A | ❑Yes | ❑No | Stroke | ❑Yes | ❑No | | | |
| Osteoporosis | ❑Yes | ❑No | Hepatitis B | ❑Yes | ❑No | Thyroid Problems | ❑Yes | ❑No | | | |
| Congenital Heart Defect | ❑Yes | ❑No | High Blood Pressure | ❑Yes | ❑No | Tuberculosis | ❑Yes | ❑No | | | |
| G.E. Reflux | ❑Yes | ❑No | HIV + AIDS | ❑Yes | ❑No | Ulcers | ❑Yes | ❑No | | | |
| Artificial Joint Replacement | ❑Yes | ❑No | Venereal Disease | ❑Yes | ❑No | Low Blood Pressure | ❑Yes | ❑No | | | |

***How did you hear about our office? Check only one***

Website ❑ Insurance Plan ❑ Billboard ❑ Newspaper Ad ❑ Social Media (Facebook, Twitter) ❑ Newspaper/Magazine ❑

Other ❑ (specify): _____ Referred by current patient: ❑ Name of patient: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand that importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient/Legal Guardian Date

**FOR COMPLETION BY DENTIST**

**Comments:** _____

_____

_____

_____

**OFFICE POLICIES** UPDATED 2017

Thank you for choosing Winter Garden Smiles for your General and Pediatric dentistry needs. We are committed to providing quality dental care for your entire family in a friendly and caring environment. The following is a summary of our office policies for your review. We will be happy to answer any questions you might have about our policies.

## Appointments

We are dedicated to staying on schedule and seeing all of our patients on time for their appointments. We do ask that our patients arrive on time for their scheduled appointment. We recommend arriving 5-10 minutes early so that you can check in and fill out any additional information that might be needed. Please be aware that dental emergencies could occur at times and this can cause a delay in your appointment. We are committed to treating all true dental emergencies and will advise you immediately as to the status of your appointment.

## Scheduling Treatment Appointments

Our office requires a ***$50.00 non-refundable scheduling deposit for our general dentist patients*** **and** ***$75.00 non-refundable scheduling deposit for our pediatric patients,*** for appointments over $300.00. This deposit will be required at time of scheduling an appointment. Rescheduling, canceling or failing to show up for your appointment without 2 business days notice will result in a loss of your deposit. Deposits will be credited towards your treatment at the time of the appointment.

## Late Policy

We expect our patients to arrive on time for their scheduled appointment. ***Please note that we will have to reschedule your appointment if you arrive more than 10 minutes late.***

## Cancellations

We reserve time especially for you. If you need to change your appointment, ***we ask for a minimum notice of 48 business hours***. ***A $25.00 charge for each half hour*** will apply to your account for rescheduling, canceling or failing to show up for your appointment without 2 business days notice. Winter Garden Smiles reserves your appointment time exclusively for you. Consecutive missed appointments can result in being dismissed as a patient. Winter Garden Smiles doesn't "double-book" and keep extra patients waiting in case you don't come to your appointment.

## Weekend and After Hours

Patients of record with true dental emergencies after regular business hours should call our office for information on how to contact one of our doctors. Our office does not have an on-call dentist to see patients during these times. We will assist you as best as we can during this time. If patients require to be seen immediately during off hours we will inform you to visit a urgent care dentist or hospital.

## General and Pediatric Patients

Patients aged 12 and under will be assigned to our pediatric dentist. Patients aged 13 and above will be assigned to one of our general dentists. Children above 13 years of age can continue to be seen by our pediatric dentist per doctor discretion.

## Financial/Insurance Policy

- **Patients without insurance coverage:** The fee for treatment rendered must be paid in full on the day of service.
- **Patients with insurance coverage:** The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all fees generated by your insurance. You are responsible for knowing your insurance coverage before your appointment.

***PLEASE UNDERSTAND*** that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or what benefits they pay on a claim. We can only assist you in **estimating** your portion of the cost of treatment. We never guarantee what your insurance will or will not pay with each claim.

**We accept Visa, MasterCard, American Express, Discover, Care Credit, and cash for payment of the amount due.** We do not accept **checks.**

## Collections

All accounts which have not paid the estimated portion of their bill at the time of service will incur a $3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur monthly 1.5% finance charge which equals an 18% per annum rate.

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. Any charges incurred during this process will be added to the account balance.

_____ _____

Patient signature/legally authorized representative Date

_____ _____

Printed name if signed on behalf of the patient Relationship

# Winter Garden Smiles
# 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 IT CAREFULLY.**

Winter Garden Smiles, hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 12/15/2016. You may access or obtain a copy according to the following options: 1) our website at www.wintergardensmiles.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you.

A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.

B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.

C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff.

i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:

D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time.

If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:

E) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.

F) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.

G) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.

H) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:

A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.

B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).

C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.

D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.

E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.

F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer.

G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.

H) Fundraising: If PHI is used for fundraising which is considered "health care operations," basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of another individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

Winter Garden Smiles
1291 Winter Garden Vineland Road, Suite 140
Winter Garden, Florida 34787
TEL: (407) 614-5955
info@wintergardensmiles.com
You will not be penalized for filing a complaint.

**HIPAA PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations. By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form; therefore payment in full is required at the time services are rendered.

**Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.**

Name: _____ Relationship: _____

Name: _____Relationship: _____

Name: _____ Relationship: _____

Signature of Patient/Legal Guardian: _____ Date:_____

---

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt for out Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify):

# Photography Release

I, _____, hereby authorize Winter Garden Smiles, Dr. Bernal/Gil/Ramdin, or assistants to take photographs, slides, and/or videos of my jaw, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational or marketing purposes in study club meetings, lectures, social media (Facebook, Instagram, etc.) seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature _____

Date _____

○ I, _____, refuse the use of my photographs for anything other than the purpose to continue my treatment.

Signature _____

Date _____