We welcome you as a patient!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you maintaining your dental health.

PATIENT INFORMATION:

Name: _____
Last *First* *Middle*

Home Phone: ( ) _____ **Social Security #:** _____ **Date of Birth:** _____

Address: _____ **E-mail:** _____

City: _____ **State:** _____ **Zip Code:** _____

Sex: ☐ **Male** ☐ **Female** **Age:** _____ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐

Patient Employer: _____ **Occupation:** _____

Business Address: _____ **Phone:** _____

In case of an emergency, who should be notified: _____ **Phone Number:** _____
Name

Whom may we thank for referring you: _____

DENTAL INSURANCE:

Person Responsible for account: _____
Last Name *First Name*

Relationship to patient: _____ **Birthdate:** _____ **Social Securtiy#** _____

Address (*if different from patient*): _____ **Phone:** _____

City: _____ **State:** _____ **Zip Code:** _____

Person Responsible Employed By: _____ **Occupation:** _____

Business Address: _____ **Phone:** _____

Insurance Company: _____ **Contact #: ( )** _____ **Group #:** _____ **Subscriber #:** _____

Names of other dependents covered under this plan: _____

MEDICAL HISTORY:

1. Are you in good health now?..... ☐ Yes ☐ No
2. Are you now under the care of a physician..... ☐ Yes ☐ No
   If so, what is the condition being treated? _____ Physcian's Name: _____
   Address: _____ Phone #: _____
3. Date of last medical examination _____
4. Have you ever been hospitalized or had a serious illness?..... ☐ Yes ☐ No
5. Have you had excessive bleeding requiring special treatment?..... ☐ Yes ☐ No
6. Are you currently taking any medication?..... ☐ Yes ☐ No
   Please list name of medication, purpose, & dosage below:
   1. _____ 2. _____ 3. _____
7. Are you **Allergic** or have you ever experienced any reaction to the following?
   Local Anesthetics (e.g. Novocain) ..... ☐ Yes ☐ No
   Barbiturates/Sedatives/Sleeping Pills... ☐ Yes ☐ No
   Penicillin/Other antibiotics..... ☐ Yes ☐ No
   Aspirin..... ☐ Yes ☐ No
   Codeine or other Narcotic..... ☐ Yes ☐ No
   Sulfa Drugs..... ☐ Yes ☐ No
   Other Allergies _____
8. (Women) Are you pregnant?..... ☐ Yes ☐ No If so, give due date _____
   Are you nursing?..... ☐ Yes ☐ No
   Are you taking Birth Control Pills? (Antibiotics may make birth control pills ineffective)..... ☐ Yes ☐ No

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

Heart failure	☐ Yes	☐ No	Tumors or growths	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	X-Ray or Cobalt Treatment	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Damaged or Artificial Heart Valves	☐ Yes	☐ No	Aids	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Hepatitis A (Infectious)	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Hepatitis B (Serum)	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Venereal Disease (Syphilis, Gonorrhea)	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Cold Sores	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Allergy, Hay fever, Sinus	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Metal Sensitivity	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	HIV	☐ Yes	☐ No

10. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor said you cannot do? If so, explain: _____

DENTAL HISTORY

1. Reason for this visit? _____
2. Last dental visit? _____ Purpose _____ Last complete exam _____
3. Do you prefer local anesthetic (Novocain) for most dental treatment? ☐ Yes ☐ No
4. Have you ever had any serious trouble associated with previous dental treatment? _____
5. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
6. Have you ever been treated for periodontal disease (Gum Disease, Pyorrhea, Trench Mouth)? ☐ Yes ☐ No
   If so, when? _____
7. Do you have or have you ever had the following?

Bleeding Sore Gums	☐ Yes	☐ No	Loose Teeth	☐ Yes	☐ No
Unpleasant Taste/Bad Breath	☐ Yes	☐ No	Sensitive to Hot	☐ Yes	☐ No
Burning Tongue/Lips	☐ Yes	☐ No	Sensitive to Cold	☐ Yes	☐ No
Frequent Blisters, Lips, Mouth	☐ Yes	☐ No	Sensitive to Sweets	☐ Yes	☐ No
Swelling/Lumps in Mouth	☐ Yes	☐ No	Sensitive to Biting	☐ Yes	☐ No
Ortho Treatment (Braces)	☐ Yes	☐ No	Food Impaction	☐ Yes	☐ No
Biting Cheeks/ Lips	☐ Yes	☐ No	Clenching/Grinding	☐ Yes	☐ No
Clicking/Popping Jaw	☐ Yes	☐ No	Complications from Extractions	☐ Yes	☐ No
Difficulty Opening or Closing Jaw	☐ Yes	☐ No	Cigarettes, Pipe, Cigar Smoking	☐ Yes	☐ No

Preferred Method of Payment: ☐ **Cash** ☐ **Check** ☐**Credit Card (MasterCard, Visa, Discover, CareCredit)**

There is a $20.00 charge for all returned checks.

Appointments: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

OFFICE POLICIES

Thank you for choosing Dr. Rosenberg as your dental health care provider. We are committed to giving you comfortable, quality treatment. You have completed a medical history form so that we can give you the best care possible, now we want to provide you with information regarding our office policies including payment and appointment information.

Payment Information:

- **Payment is expected in full at time of visit**
- **We gladly accept cash, check, MasterCard, Visa, and Discover**
- **We participate with CareCredit and Capital One payment plans. Both offer no interest for 12 months. If interested, please inquire prior to your appointment.**
- **Our Financial Coordinator will be happy to meet with you prior to treatment to discuss what your payment, estimated co-payment, and deductibles will be.**

If You Have Insurance:

Our administrative staff prides itself on helping our patients maximize their benefits and we are always available to answer your questions.

Insurance Subscribers
Please present your card to the front office prior to your appointment. Obviously, we cannot guarantee the amount of payment to be made by an insurance company but we will promptly submit claims upon services rendered and ESTIMATE your portion. This ESTIMATED portion is due at the time of visit. Should the insurance company pay an amount other than what was estimated, you would receive a statement reflecting the difference. If the insurance company has not submitted payment to our office within 60 days, the balance in full will be billed to the patient.

Minor Patients:

The adult accompanying a minor and the parents (or guardians) are responsible for full payment, regardless of court child support order. For unaccompanied minors, non-emergency treatment will not be done unless prior approval and financial arrangements have been made.

Appointment Information:

We are happy to help you find a convenient appointment time and we understand that there will be occasions when you will need to reschedule. We ask that you give us 48-hour advance notice to reschedule an appointment. Failed appointments are subject to a fee.

PLEASE LET US KNOW IF WE CAN CLARIFY ANY INFORMATION FOR YOU!!
WE ARE PLEASED TO HAVE YOU AS A PATIENT IN OUR PRACTICE
AND LOOK FORWARD TO TAKING CARE OF YOUR SMILE!

_____ _____

Signature of Financially Responsible Party Date

HIPAA NOTICE OF PRIVACY RIGHTS

This notice describes how Dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Notice of Privacy Practices describes how we may use and disclose your protected health information [PHI] to carry out treatment, payment or health care operations [TPO] and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your dental provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the corporations practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a dental provider to whom you have been referred to ensure that the dental provider has the necessary information to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your dental services. For example, obtaining eligibility or benefits may require that your relevant protected health information be disclosed to the dental plan to obtain the information.

Operations: We may use or disclose, as needed, your protected health information in order to support the business activities, training of dental students, licensing and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk; we may also call you by name in the waiting room when your technician is ready to see you; or as necessary, to contact you to remind you of your appointment.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including but not limited to voicemail messages, postcards or letters.

We may use disclose your protected health information in the following situations without your authorization: as required by law; Public Health issues; Communicable Diseases; Health Oversight Committees; Abuse or Neglect; Food and Drug Administration requirements; Legal proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal activity; Military activity; National Security; Worker's Compensation. Inmates: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

Revocation of Authorization: At any time, in writing, except to the extent that your dental provider or the dental practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Right to inspect or copy your PHI: Under federal law, however, you may not inspect or copy information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access.

Right to request a restriction of your PHI: You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must be in writing and must state the specific restriction requested and to whom you want the restriction to apply. The facility is not required to agree to a restriction that you may request. If the Dental Director or his appointees believes it is in your best interest to permit use and disclosure of your protected health information, your PHI will not be restricted.

Right to alternative communications: You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

Right to obtain a paper copy: Upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

Right to amend your PHI: The facility has the right to deny your amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to accounting disclosures: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

_____ _____ _____

Print Name Signature Date

Relationship to patient (if signed by a representative of patient): _____

Scott Rosenberg D.M.D
4600 Military Trail Suite A 220 / Jupiter, Florida 33458 / 561-626-6993