SMILE ST. PETE DENTISTRY

DEBORAH LOWRY, DMD

PLEASE FILL OUT BOTH SIDES

PATIENT INFORMATION: THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR DENTAL NEEDS. PLEASE COMPLETE THIS FORM IN INK. IF YOU HAVE ANY QUESTIONS, DO NOT HESITATE TO ASK FOR ASSISTANCE. WE WILL BE HAPPY TO HELP.		
NAME: (FIRST, MI, LAST) - PLEASE PRINT		DATE:
ADDRESS:	CITY:	STATE/ ZIP:
	CELL PHONE #	HOME PHONE #:
SOCIAL SECURITY #:	DATE OF BIRTH:	
DRIVER LICENSE NUMBER / STATE:	**E-MAIL ADDRESS:**	
ARE YOU: (CIRCLE ONE) MINOR SINGLE MARRIED SEPARATED DIVORCED WIDOWED		
NAME OF YOUR EMPLOYER:		OCCUPATION:
BUSINESS ADDRESS/ CITY/ STATE/ ZIP		WORK PHONE #:
IF YOU ARE A STUDENT, NAME OF SCHOOL/ COLLEGE:		
CONTACT IN CASE OF EMERGENCY:		PHONE #:
WHOM MAY WE THANK FOR REFERRING YOU TO US?		
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:		RELATIONSHIP TO PATIENT:
ADDRESS/ CITY/ STATE/ ZIP		HOME PHONE #:
NAME OF EMPLOYER:		WORK PHONE #:
PRIMARY DENTAL INSURANCE INFORMATION		
NAME OF INSURED:		RELATIONSHIP TO PATIENT:
SOCIAL SECURITY #:	DATE OF BIRTH:	DATE EMPLOYED:
EMPLOYER NAME:		WORK PHONE #:
NAME OF INSURANCE COMPANY:		GROUP #:
INSURANCE ADDRESS/ CITY/ STATE/ ZIP		PHONE #:

SEE OTHER SIDE

SECONDARY DENTAL INSURANCE INFORMATION

NAME OF INSURED:		RELATIONSHIP TO PATIENT:
SOCIAL SECURITY #:	DATE OF BIRTH:	DATE EMPLOYED:
NAME OF INSURANCE COMPANY:		GROUP #:
INSURANCE ADDRESS/ CITY/ STATE/ ZIP		PHONE #:

DENTAL HISTORY INFORMATION

FORMER DENTIST	ADDRESS/ CITY/ STATE/ ZIP		
DATE OF LAST DENTAL EXAM:	DATE OF LAST X-RAYS:	HOW OFTEN DO YOU BRUSH?	HOW OFTEN DO YOU FLOSS?
REASON FOR TODAY'S VISIT:			

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:
BAD BREATH / BLEEDING GUMS / CLICKING OR POPPING JAW / FOOD COLLECTION BETWEEN TEETH / GRINDING TEETH / LOOSE TEETH OR BROKEN FILLINGS / PERIODONTAL TREATMENT / SENSITIVITY TO COLD / SENSITIVITY TO HOT OR SWEET / SENSITIVITY TO BITING / SORES OR GROWTHS IN YOUR MOUTH

MEDICAL HISTORY

PHYSICIAN:	DATE OF LAST VISIT:

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING **BISPHOSPHONATES**:

RALOXIFENE ____ SKELID _____ FOSAMAX ______ AREDIA ______ ZOMETA ______ ACTONE _______

ALLERGIES:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

For female patients:

Are you pregnant? **Y / N**
Nursing? **Y / N**
Taking Birth Control Pills? **Y / N**

DO YOU HAVE A HISTORY OF THE FOLLOWING:

□ ACID REFLUX/GERD	□ COUGH, PERSISTENT	□ HIGH CHOLESTEROL	□ RESPIRATORY DISEASE
□ ANEMIA	□ COUGH UP BLOOD	□ HISTORY OF SMOKING	□ SCARLET FEVER
□ ARTHRITIS, RHEUMATISM	□ DIABETES	□ HIV POSITIVE	□ SHORTNESS OF BREATH
□ ARTIFICIAL HEART VALVES	□ EPILEPSY	□ JAW PAINS	□ SKIN RASH
□ ARTIFICIAL JOINTS	□ FAINTING	□ KIDNEY DISEASE	□ STROKE
□ ASTHMA	□ GLAUCOMA	□ LIVER DISEASE	□ SWOLLEN FEET/ANKLES
□ AUTOIMMUNE DISORDER	□ HEADACHES	□ MITRAL VALVE PROLAPSE	□ THYROID PROBLEMS
□ BACK PROBLEMS	□ HEART MURMUR	□ NERVE PROBLEM/NEURALGIA	□ TOBACCO HABIT
□ BLOOD DISEASE	□ HEART PROBLEMS	□ OSTEOPOROSIS	□ TONSILLITIS
□ CANCER* PLEASE SPECIFY	□ HEMOPHILIA	□ PACEMAKER	□ ULCERS
□ CHEMICAL DEPENDENCY	□ HPV	□ PSYCHIATRIC CARE	□ CLICKING AND POPPING OF TMJ
□ CHEMOTHERAPY	□ HEPATITIS	□ RADIATION TREATMENT (PAST OR PENDING)	□ **NONE**
□ CIRCULATORY PROBLEMS	□ HIGH BLOOD PRESSURE		

AUTHORIZATION

I CERTIFY THAT I HAVE READ AND UNDERSTAND THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILDREN DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYOR AND/OR HEALTH PRACTITIONER. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL CARRIER MY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

PATIENT'S SIGNATURE (OR PARENT IF A MINOR): **DATE:**

SMILE ST. PETE
DENTISTRY

DEBORAH LOWRY, DMD

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

____

Date Patient Name

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other ____________________

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO:

YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

____

Name Relationship

____

Name Relationship

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:**

☐ Cell Phone Confirmation ☐ Email Confirmation

☐ Text Message to my Cell Phone ☐ Work Phone Confirmation

☐ Home Phone Confirmation ☐ **Any of the Above**

SEE NEXT PAGE

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DEBORAH LOWRY, DMD

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Home Phone Confirmation
- ☐ Email Confirmation
- ☐ Work Phone Confirmation
- ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ **Any of the Above**
- ☐ **None of the Above (opt out)**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

____

Please print name of Patient

Please sign Patient / Guardian of Patient

____

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because ______________________
- ☐ Other ______________________

Signature of Privacy Officer______________________

HIPAA mAde eASY® / ©2009/2017 All Rights Reserved HIPAA MANUAL to oMNIBUS RULE StANDARD

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As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18%) per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Photographs: I agree to allow Dr. Deborah Lowry, DMD, PA and her agents to use the photographs of any portion of my dental treatment for the purpose of teaching, in dental & health publications, and any marketing or advertising medium. At no time will the patient's name, address, or any other patient identifiable information be used in connection with the publication of the photographs and/or images of the patient.

I grant my permission to you or your assignee, to telephone me at home, on my cell or at my work to discuss matters related to this form.

** 48 hours advance notice is required to avoid a cancellation fee of $75 per hour booked for missed appointment. I have read the above conditions of treatment and payment and agree to their content.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN | DATE | RELATIONSHIP TO PATIENT:

SIGNATURE OF GUARANTOR OF PAYMENT/RESPONSIBLE PARTY | DATE | RELATIONSHIP TO PATIENT: