ORLANDO FAMILY & COSMETIC DENTISTRY

3191 Maguire Blvd, Suite #251
Orlando, Florida 32803
407-894-1451 phone
407-894-5656 fax

PATIENT INFORMATION

Legal Name of Patient____________________________________Nickname______________________

Address_______________________________________City_________________State_____Zip_______

Cell Phone#_____________________Home#_____________________Work#______________________

Date of Birth____/____/_____Age______ Social Security#______-______-______ Sex: Male / Female

Driver's License# ___________________________State____ Email____________________________

Circle One: Minor Single Married Separated Divorced Widowed Long-Term Partner

Employer____Occupation___________________________

Who referred you to our office ____

PRIMARY DENTAL INSURANCE

Name of Insured_________________________________ Relationship to Patient___________________

Insured's address if different than above _____________________City__________ State____ Zip______

Cell Phone#____________________ Home#_____________________ Work#______________________

Date of Birth____/____/_____Social Security#______-______-______ Sex: Male / Female

Name of Insurance Company_____________________________________Group#__________________

Address of Insurance Company_________________________City_____________State_____Zip______

Subscriber I.D. # or Member #__________________________Toll Free Phone # (_____) _____-_______

Employer Name____________________________________Occupation__________________________

SECONDARY DENTAL INSURANCE

Name of Insured_________________________________ Relationship to Patient___________________

Insured's address if different than above ________________________________State_____ Zip_______

Cell Phone#____________________ Home#_____________________ Work#______________________

Date of Birth____/____/_____Social Security#______-______-______ Sex: Male / Female

Name of Insurance Company_____________________________________Group#__________________

Address of Insurance Company_________________________City_____________State_____Zip______

Subscriber I.D. # or Member #__________________________Toll Free Phone # (_____) _____-_______

Employer Name____________________________________Occupation__________________________

Signature of Patient or Guardian____Date___________

Is Patient a Minor YES / NO If Yes, Print Name of Parent/Guardian__________________________

MEDICAL HISTORY

Patient Name	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?

____

____

Date of Last Dental Visit __________ **Last Dental Cleaning** ___________ **Last Full Mouth X-rays** __________

Previous Dentist's Name ____

Address ____State________Zip___________

Phone ____

Do you have any dental problems now? ……………………………………………………………Yes No

If yes, please list ____

Is there anything you would change about your smile or oral health? ……………………………Yes No

If yes, please list ____

Are any of your teeth sensitive to:

Hot or Cold? ……………………………………………………………………………………Yes No

Sweets? ………………………………………………………………………………………Yes No

Biting or Chewing? ……………………………………………………………………………Yes No

Have you noticed any mouth odors or bad tastes? ………………………………………………Yes No

Do your gums bleed or hurt? …………………………………………………………………………Yes No

Have you noticed any loose teeth or change in your bite? ………………………………………Yes No

Does food tend to become caught in between your teeth? ………………………………………Yes No

Have you ever had a "deep cleaning" or any type of periodontal treatment? ……………………Yes No

Do you smoke or chew tobacco? ………………………………………………………………………Yes No

Do you clench or grind your teeth while awake or asleep? …………………………………………Yes No

Do you or have you experienced popping or clicking of the jaw? ………………………………Yes No

Do you or have you experienced pain in your jaw? ……………………………………………………Yes No

Are your teeth yellow or heavily stained? ……………………………………………………………Yes No

Are you interested in tooth whitening? ………………………………………………………………Yes No

Are you unhappy with the alignment of your teeth? ……………………………………………………Yes No

With respect to your past dental experience; Is there anything we should repeat or avoid? Is there anything that happened in another dental office we should be sensitive to? Is there anything else we can do to make you more comfortable? ____

____

____

____

MEDICAL HISTORY

Patient Name	**Medical Alert**

1.) Have you been under the care of a medical doctor during the past two years? ....Yes No

If yes, for what? ____

Physician's Name____Phone____________________

Address__________________________________City__________________State_______Zip_________

2.) Are you taking any medication, drugs, or pills now? ....Yes No

****If yes, please list on the BOTTOM of this form**

3.) Are you aware of having an allergic (**or adverse reaction**) to any medication or substance? ....Yes No

If yes, please list; ____

____

____

4.) Have you been a patient in the hospital during the past five years? ....Yes No

If yes, please explain; ____

5.) Indicate which of the following you have had, or have at the present. **Circle "Y"es or "N"o to each item**.

Heart (Surgery,Disease,Attack)	Y	N	Ulcers	Y	N	Hepatitis A(Infectious)B(Serum)	Y	N
Chest Pain	Y	N	Diabetes	Y	N	Venereal Disease	Y	N
Congenital Heart Disease	Y	N	Thyroid Problems	Y	N	A.I.D.S.	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	H.I.V. Positive	Y	N
High Blood Pressure	Y	N	Contact Lenses	Y	N	Cold Sores/Fever Blisters	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N	Blood Transfusion	Y	N
Artificial Heart Valve	Y	N	Chronic Cough	Y	N	Hemophilia	Y	N
Heart Pacemaker	Y	N	Tuberculosis	Y	N	Sickle Cell Disease	Y	N
Rheumatic Fever	Y	N	Asthma	Y	N	Bruise Easy	Y	N
Arthritis/Rheumatism	Y	N	Hay Fever	Y	N	Liver Disease	Y	N
Cortisone Medicine	Y	N	Latex Sensitivity	Y	N	Yellow Jaundice	Y	N
Swollen Ankles	Y	N	Allergies or Hives	Y	N	Neurological Disorders	Y	N
Stroke	Y	N	Sinus Trouble	Y	N	Epilepsy or Seizures	Y	N
Diet (special/restricted)	Y	N	Radiation Therapy	Y	N	Fainting or Dizzy Spells	Y	N
Artificial Joints (Hip,Knee,Etc.)	Y	N	Chemotherapy	Y	N	Nervous/Anxious	Y	N
Kidney Trouble	Y	N	Tumors	Y	N	Psychiatric/Psychological Care	Y	N

6.) Do you or have you had any disease, condition, or problem not listed ....Yes No

If yes, please list: ____

7.) Do you **pre-medicate** with an antibiotic prior to any kind of dental treatment? ....Yes No

8.) **WOMEN** Are you: **Pregnant**? Yes, ___Months No **Nursing**? Yes No **Taking birth control pills**? Yes No

LIST OF MEDICATIONS; **	**REVIEW OF MEDICAL HISTORY** (FOR OFFICE USE ONLY) .
	____ ____ ____ ____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

PATIENT/GUARDIAN SIGNATURE____DATE_______________

DENTIST SIGNATURE ____DATE_______________

ORLANDO FAMILY & COSMETIC DENTISTRY

3191 Maguire Blvd Suite 251
Orlando, Florida 32803

FINANCIAL POLICY

We are pleased that you have selected us as your dental care provider. For your knowledge, our Financial Policy is outlined below.

Promise to Pay. Amounts for dental care services provided to you or your family members may be charged to your Account, unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have dental insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with a dental insurance claim as long as the correct insurance information is given before time of service. If there is a change in insurance we ask you provide us with the updated information 24 hours in advance. We do not accept or file Medical Insurance. If you have a secondary insurance you will be expected to pay your portion based on your primary insurance only. As a courtesy we will help you file your secondary insurance claim, but the payment will be made directly to the insured member of the secondary insurance. Insurance is a contract between the policy holder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your Account is your full responsibility. We may also charge to your Account fees set forth below for missed appointments, late payments, returned payments or collection costs. We will provide to you a statement (your "Statement") of your Balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have insurance coverage, we may choose not to send you a Statement until we know or receive the amount reimbursable by your insurance company.

Missed Appointment Fee. We may charge to your Account fees of $50/Hour for a missed appointment or fees for an appointment cancelled without advance notice of at least 48 hours.

Late Payment Fee. If we do not receive payment in full of your Balance within 30 days of the statement date shown on your Statement, you will be assessed a Late Payment Fee of $10.00 for each month your full Balance goes unpaid. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your Balance.

Returned Payment Fee. If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Returned Payment Fee, which is currently $35.00 and may be adjusted due to fluctuating bank charges.

Collection Cost. If we do not receive payment under the terms of this Financial Policy and we refer your Account to a collection agency or an attorney for collection, we may charge to your Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees, to the extent not prohibited by applicable law.

No Waiver by Us. We may waive our right to charge a fee to your Account without waiving any other right we have under this Financial Policy including our right to charge that same fee at any other time.

Credit Reports. We, or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other defaults on your account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or may report inaccurate information to a collection agency, please notify us of the specific information that you believe is inaccurate by writing to us at the address above.

As used in this Financial Policy, "we," "us," "our" and "Provider" mean the service provider named above (Orlando Family & Cosmetic Dentistry). "Services" means any services provided by us. "You," "your' and "Account holder" mean the person responsible for paying for services. Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your "Account") as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this Financial Policy.

Yes, I agree to the above terms and conditions.

____

Account Holder's Signature Print Name Date

ORLANDO FAMILY & COSMETIC DENTISTRY

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 right 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 01/01/2003, 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

Treatment: We may use or disclose your health information to a physician or other 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 to 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 a filled prescription, 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 a correctional institution or law enforcement official having lawful custody of protected health information of an 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, 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 for each page, 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 communicate with you about 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 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.

Orlando Family & Cosmetic Dentistry
Dr. Sanjay Ghetiya
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407-894-1451

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ORLANDO FAMILY & COSMETIC DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF
OUR PRIVACY PRACTICES (HIPPA) AND OFFICE POLICIES

You May Refuse to Sign This Acknowledgement

I, ____, have been presented with the Notice of Privacy Policy (the "Policy") of Orlando Family & Cosmetic Dentistry (the "Provider") and have been offered a copy of such policy to keep for my records.

____

Please Print Name

____

Signature

____

Date

If you would like to permit our office to speak to someone other than yourself, the above named, regarding your treatment please list name(s);

____

____