Smile Viera

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5600 Porada Dr | Suite 101 • Viera, FL 32940 (321)631-9395

New Patient Health & Dental Questionnaire

As required by law, our office adheres to written policies and procedures so that your personal information is kept private and confidential. Your information is for our records only and will be kept confidential subject to applicable laws. We may further ask you to provide us with supporting information after your completed health and dental history. Your accurate and complete medical and dental information is vital in allowing us to treat you safely. Your answers to any question on this questionnaire are non discriminatory.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**** Providing us with all of the above required information will allow us to communicate with you more efficiently throughout your experience with our office.**

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Do you have insurance? ◯ Yes ◯ No

Primary Dental Insurance Information

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance company phone number: _____

Previous Dental Office Information

Name of previous dental office

Phone number of previous dental office

Secondary Dental Insurance Information

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance company phone number : _____

Whom may we thank for referring you to our practice?

☐ Insurance Company	☐ Internet Search	☐ Website	☐ Drive By	☐ Viera Voice	☐ Postcard
☐ Savings Safari	☐ Other	☐ Personal Referral	☐ TV	☐ Radio	

Please provide the name of the person referring you to our practice. _____

Dental Information

What is the reason for your dental visit?

When was the approximate date of your last dental visit?

Is there anything else you want to discuss with your dentist?

Anxiety

Are you nervous during dental visits? ◯ Yes ◯ No

Are you interested in learning more about how we can reduce your nervousness with nitrous oxide "laughing" gas or conscious sedation (pills / IV)?

◯ Yes ◯ No

TMJ

Please mark the following to indicate a YES response.

- ☐ Has anyone ever said you grind or clench your teeth?
- ☐ Do you have any pain,popping or clicking of your jaw joint?
- ☐ Do you ever have headaches, sore jaw muscles, or sore teeth in the morning?
- ☐ Do you now have or have you ever worn a nightguard?

FOR DOCTOR USE ONLY

Do you smoke (cigars/cigs/pipes/drugs) or chew tobacco? If yes, how many per day and for how many years?

Do you drink alcoholic beverages? If yes, how many drinks per week?

Women Only

Are you pregnant? ◯ Yes ◯ No

Number of weeks _____

Please mark any that apply

☐ Are you nursing

☐ Are you planning on getting pregnant

☐ Are you taking Birth Control or Homonal Replacement Pills

Allergies

Are you ALLERGIC to any of the following? Check all that apply to you.

- ☐ Local Anesthetics
- ☐ Aspirin
- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Sulfa Drugs
- ☐ Codeine
- ☐ Narcotics, Sedatives, or Sleeping Pills
- ☐ Bleach
- ☐ Latex
- ☐ Metals
- ☐ Iodine
- ☐ Animals/Food
- ☐ Hay Fever/Seasonal
- ☐ Other

FOR DOCTOR USE ONLY:

Premedication

Check any that apply:

- ☐ Joint Replacement
- ☐ Artificial Heart Valve
- ☐ Damaged valves in transplanted heart
- ☐ Congential Heart Disease (CHD)
- ☐ Unrepaired Cyanotic (CHD)
- ☐ Repaired in the last 6 months
- ☐ Repaired CHD with further problems

FOR DOCTOR USE ONLY:

Medical Information

Do you now, or have you ever had any of the following conditions?

- ☐ 01.High Cholesterol
- ☐ 02.Chest Pains
- ☐ 03.Cong. Heart Fail
- ☐ 04.Damaged Heart Val
- ☐ 05.Heart Attack
- ☐ 06.Heart Murmur
- ☐ 07.High Blood Press
- ☐ 08.Low Blood Press
- ☐ 09.MVP
- ☐ 10.Pacemaker
- ☐ 11.Rheumatic Fever
- ☐ 12.Stroke
- ☐ 13.Abnormal Bleeding
- ☐ 14.Anemia
- ☐ 15.Blood Transfusion
- ☐ 16.Diabetes
- ☐ 17.Hemophelia
- ☐ 18.HIV/AIDS
- ☐ 19.STD
- ☐ 20.Autoimmune Dis
- ☐ 21.Rheumatoid Arth
- ☐ 22.Lupus
- ☐ 23.Acid Reflux
- ☐ 24.Ulcers
- ☐ 25.Hepatitis
- ☐ 26.Jaundice
- ☐ 27.Kidney Disease
- ☐ 28.Liver Disease
- ☐ 29.Recurrent Infect
- ☐ 30.Anxiety
- ☐ 31.Depression
- ☐ 32.Epilepsy
- ☐ 33.Fainting Spells
- ☐ 34.Neurological Dis
- ☐ 35.Seizures
- ☐ 36.Severe Headaches
- ☐ 37.Asthma
- ☐ 38.Bronchitis
- ☐ 39.Emphysema
- ☐ 40.Sinus Trouble
- ☐ 41.Tuberculosis
- ☐ 42.Thyroid Problems
- ☐ 43.Swollen Glands
- ☐ 44.Glaucoma
- ☐ 45.Chronic Pain
- ☐ 46.Cancer
- ☐ 47.Chemotherapy
- ☐ 48.Radiation Treat
- ☐ 49.OTHER
- ☐ 50.Eating Disorder
- ☐ 51.Weight Changes
- ☐ 52.Excess Urination
- ☐ 53.Night Sweats
- ☐ 54.Osteoporosis
- ☐ 55. Arthritis

Have you completed this portion of the questionairre? ◯ Yes ◯ No

Medications

List EVERY medication, supplement, herbal, or vitamin you take and WHY you are taking them. (If you have a list, you may paste your list here).

Surgeries

List EVERY surgery you have ever had. (If you have a list, you may paste it here).

FOR DOCTOR USE ONLY:

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your payment. PAYMENT IS DUE AT THE TIME SERVICE IS PROVIDED. Our office accepts cash, personal checks, debit cards, Mastercard, Visa, and Discover. Outside financing is available upon request and approval. Would you like more information about financing options?

◯ Yes ◯ No

Please note: Returned checks will be subject to an additional $25.00 return fee. In the case it becomes necessary to our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred at the highest rate permitted under the applicable law of Florida.

A $75.00 CHARGE WILL BE ASSESSED FOR CANCELLATION OR RESCHEDULED APPOINTMENTS WITH LESS THAT 24 HOURS NOTICE BEFORE YOUR SCHEDULED APPOINTMENT, REGARDLESS OF THE REASON.

DO YOU HAVE INSURANCE?

* As a courtesy to you, we will help you process all of your insurance claims. Please understand that we will provide an insurance estimate to you, however, is it not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your benefits ultimately determine the amount paid. We will, of course, do all that we can to make sure your estimate is accurate as possible.
* All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
* Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for the payment regardless of any insurance company's arbitrary determination of usual and customary rates.
* We ask that you sign this form and/or other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payments directly to our office.
* We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company bu cash, check debit card, Mastercard, Visa, or Discover at the time we provide the service to you.
* Insurance payments are ordinarily received within 30 to 60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for playing the full amount at that time.
* We will cooperate fully with the regulations and request of your insurance company that may assist in the claim being paid. Our office will not, however enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental healthcare needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THIS DENTAL OFFICE.

CONSENT:

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, deemed payable at the time the services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

PATIENT NAME (please type the the box below):

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the 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 inquiries 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 or do not take because of errors or omissions that I may have made in the completion of this form.

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 CAREFULLY. THIS 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. Protection of patient privacy is important to us. This notice summarizes the privacy practices that will be followed by Celebrity Smiles dental practice. 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 October 1, 2011. 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 changes in our privacy practices and the new terms of our Notice effective for all health information 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 your treatment:

For example, we may use or disclose your health information to another dentist, physician, or other health care provider providing treatment for 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:

Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect.

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 involved in your treatment to the extent necessary to help your healthcare

Persons Involved In Care:

We will also use our professional judgement 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 or a possible victim of abuse, neglect, or domestic violence other possible visit 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, postcards, letters, or emails).

PATIENT RIGHTS Access:

You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the 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 as the end of this Notice. If you request copies, we will charge you $2.00 for each page, $15.00 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 may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last six years, but not before October 1, 2011. 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 may 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 Communications:

You may 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 expatiation how payments will be handled under the alternative means or location you request. We may agree to reasonable requests.

Amendment:

You may 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, of 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 th 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 of you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact: James D. Roppa, D.D.S.

Telephone: (321) 631-9395

E-mail: drroppa@yahoo.com

Address: 5455 Murrell Rd. STE 108 Viera, FL 32955

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose:

This form is used to obtain acknowledgement of receipt or our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I have

☐ Reviewed a copy ☐ Received a copy ☐ Refused a copy

of this office's Notice of Privacy Practices.
(Please enter patient name in below box provided)

Patient signature/Parent or guardian signature if patient is a minor

Signature _____ **Date** _____

****You May Refuse to Sign This Acknowledgement****

Authorization to Release Information

Purpose:

This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I authorize the following person/persons to have access to information covered under the Privacy Practice regarding myself. (please list the name/names and their relationship to you in the area provided below)

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prevented us from obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify below)

Response Date: _____