Suncoast DENTAL

MEDICAL ALLERTS

(PLEASE PRINT)

NAME (first): _____

(last): _____

ADDRESS: _____

CITY: _____ STATE: _____ZIP:_____

HOME PHONE: _____WORK#_____

EMAIL:_____CELL#_____

DATE OF BIRTH: _____SS#_____

EMPLOYER: _____

INSURANCE COMPANY: _____

DATE OF LAST PHYSICAL? _____

NAME OF PHYSICIAN?_____

PHYSICIAN'S PHONE NUMBER: _____

IN CASE OF EMERGENCY NOTIFY? _____

_____

EMERGENCY #_____

HOW DID YOU HEAR ABOUT SUNCOAST DENTAL? _____

_____

YOUR REASON FOR TODAY'S VISIT? _____

DENTAL/HEALTH INFORMATION- CONFIDENTIAL

DR. SIGNATURE FOR MEDICAL HISTORY AND UPDATES. DATE: _____ DR. SIGNATURE: _____

DATE: _____ DR. SIGNATURE:_____ DATE: _____ DR. SIGNATURE:_____

DO YOU HAVE ANY HISTORY OF:	YES	NO
1. RHUEMATIC FEVER……	____	____
3. HEART TROUBLE……	____	____
5. STINTS……	____	____
7. HIGH BLOOD PRESSURE……	____	____
9.BLOOD DISEASE……	____	____
11. DIABETES……	____	____
13. DO YOU BRUISE EASILY……	____	____
15. KIDNEY DISEASE……	____	____
17. LIVER DISEASE……	____	____
19. TUBERCULOSIS……	____	____
21. EPILEPSY……	____	____
24. FAINTING OR DIZZINESS……	____	____
26. ARE YOU PREGNANT……	____	____
28. VENERAL DISEASE, HERPES……	____	____
30. ARE YOU PRESENTLY UNDER CARE OF A PHYSICIAN, IF YES WHY…_____		
31. HAVE YOU EVER HAD TO PREMEDICATE BEFORE YOUR DENTAL APPOINTMENT BEFORE?…..	____	____

IS THERE ANY MEDICAL PROBLEM NOT LISTED YOU WOULD LIKE TO DISCUSS? YES____ NO_____

_____

LIST ANY MEDICATIONS YOU ARE TAKING: _____

_____

_____

LIST ANY MEDICATIONS YOUR ARE ALLERGIC TO: _____

_____

_____

MEDICAL	YES	NO
2. HEART MURMUR……	____	____
4. ARTIFICIAL JOINTS……	____	____
6. PACEMAKER/HEART SURERY..	____	____
8. LOW BLOOD PRESSURE…	____	____
10. H.I.V. POSITIVE……	____	____
12. EXCESSIVE BLEEDING……	____	____
14. ANEMIA……	____	____
16. ULCERS OR STOMACHE PROBLEMS	____	____
18. LUNG DISEASE……	____	____
20. ASTHMA OR BREATHING ISSUES….	____	____
22. ALLERGIES TO DRUGS, LIST BELOW	____	____
25. DO YOU TAKE ANY MEDICATIONS..	____	____
27. IF PREGNANT HOW MANY MONTHS	_____	
29. ARTHRITIS……	____	____

DENTAL	YES	NO
1. TROUBLE WITH DENTAL CARE……	____	____
2. PAIN IN JAW OR NEAR EARS……	____	____
3. UNHEALED INJURIES OR INFLAMED AREAS IN OR AROUND MOUTH……	____	____
4. GROWTHS IN MOUTH……	____	____
5. MOUTH HURTS WHEN CLENCHED…	____	____
6.EVER HAD LOCAL ANESTHETIC……	____	____
7. EVER HAD NITROUS OXIDE……	____	____
8. EVER HAD GENERAL ANESTHETIC..	____	____
9. ANY REACTION/ALLERGIC SYMPOMS TO NOVACAINE, GENERAL OR LOCAL ANESTHETIC..	____	____
10. ANY DIFFICULT EXTRACTIONS	____	____
11. PROLONGED BLEEDING……	____	____
12. DO YOUR GUMS BLEED……	____	____
13. BAD TASTE IN MOUTH OR ODOR	____	____
14. CHEW ONLY ON ONE SIDE ……	____	____
15. HABITUALLY CLENCH OR GRIND TEETH DAY OR NIGHT? ……	____	____
16. ANY PART OF MOUTH SENSITIVE TO PRESSURE OR IRRITANTS (Hot, Cold, Sweets) LIST: _____	_____	

_____

17. DATE OF LAST DENTAL VISIT:_____
18. DATE OF LAST DENTAL X-RAYS: _____
19. IF WEARING DENTURES HOW OLD?_____

DATE: _____PATIENT OR GUARDIAN SIGNATURE_____

TREATMENT PLAN RELEASE

I AUTHORIZE SUNCOAST DENTAL TO PERFORM THE NECESSARY TREATMENT PLAN

DATE: _____PATIENT OR GUARDIAN SIGNATURE_____

AUTHORIZATION OF PAYMENT OF BENEFITS

I HEARBY AUTHORIZE PAYMENT DIRECTLY TO SUNCOAST DENTAL I AGREE THAT A PHOTOCOPY IS VALID AS THE ORIGINAL

DATE: _____PATIENT OR GUARDIAN SIGNATURE_____

PAYMENT AGREEMENT

IN THE EVENT THAT THIS ACCOUNT BECOMES PAST DUE AND IS TURNED OVER FOR COLLECTIONS, I AGREE TO PAY AN ADDITIONAL COLLECTION FEE BASED ON THE TOTAL AMOUNT DUE. ALL PAST DUE ACCOUNTS MAY BE CHARGED 1 ½ % FINANCE CHARGE MONTHLY. I UNDERSTAND THAT SUNCOAST DENTAL MAY NOT TREAT ME IF I DO NOT SIGN THE FINANCIAL AGREEMENT.

DATE: _____PATIENT OR GUARDIAN SIGNATURE_____

SUNCOAST DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____

SECTION B: PATIENT-PLEASE READ THE FOLLOWING CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and other important matters concerning your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, Including any revisions, by contacting:

craig cherwinski
Phone: 623-584-9910
Fax: 623-584-9940
13706 W. Bell Rd. Ste 2
Surprise, AZ 85374

I, _____, have had full opportunity to read and consider the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature: _____ Date: _____

If patient is a minor, or a personal representative is signing this form please complete the following:

Personal representative's name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

REVOCATION OF CONSENT:
You have the right to revoke your consent at anytime by giving us written notice of your revocation. Submit your revocation to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent, before we received your revocation. Also understand that we may decline to treat you or continue treating you if you revoke this consent.

REFUSAL TO SIGN:
If you refuse to sign this form, understand that we may not be able to treat you. Some methods of treatment require us to release your information. If we are able to treat you it will be as a cash only basis.

SUNCOAST DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____ Individual refused to sign

_____ Communication barriers prohibited us

_____ An emergency situation prevented us

_____ Other (Please Specify Below)

_____

_____

SUNCOAST DENTAL

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 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 on April 14th 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 anytime, provided the applicable law permits such changes. 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 a 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 the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your 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 provided.

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, 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 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 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 puck up filled prescriptions, medical supplies, or other similar forms of health information.

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, 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, countentelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials 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, 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 per patient file.

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 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 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 view this notice by email, you are entitled to a written copy.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy policies or have questions or concerns, please contact:

Craig Cherwinski
Phone: 623-584-9910

13706 W. Bell Rd Ste. 2
Surprise, AZ 85374

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, you may complain to us using the contact information above. You also may submit a written complaint to the U.S. Department of Health and Humans Services. We can provide you with the address upon request.

We support your right to 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.