SMILES ON HAMPTON
General Dentistry
AMBER D. ROWE, DDS

1301 HAMPTON ST
CLERMONT, FL 34711
PHONE: (352) 394-3001

PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____

Patient Name: Last_____ First_____ MI_____

Male_____ Female_____ Date of Birth_____ Age____ SS#_____

Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

Cell Phone_____ Home Phone_____ Other _____

Email Address_____

Mailing Address_____

City_____ State_____ Zip Code_____

Employer Name_____ Occupation_____

Do you have Dental Insurance? Yes_____ No_____

Name of Policy Holder_____ Policy Holders D.O.B._____

Relationship to Policy Holder_____

Name of Dental Insurance_____ Member ID_____

Group Name _____ Group Number _____

How did you hear about our office? Website_____ Google_____ Facebook_____ Other_____

Whom may we thank for referring you? _____

In case of emergency please notify:_____ Phone_____

Appointment Policy

We require 48 hour notice for appointment cancellations. Appointment charges without adequate notice may be subject to a fee of $50.00, payable by the patient and not the insurance company.

Signature_____

MEDICAL HISTORY

Physician's Name_____ Phone #_____

Date of last Physical Exam_____

Preferred Pharmacy_____ Phone #_____

Please Circle any of the following conditions that apply to you, past or present.

Anemia	Circulatory Problems	Herpes	Osteoporosis
Arthritis	Cold Sores	HIV/AIDS	Pacemaker
Artificial Valve or Joints	Depression	High Blood Pressure	Psychiatric Care
Asthma	Diabetes	Jaundice	Rheumatic fever
Aspirin/Blood Thinners	Epilepsy	Kidney Disease	Respiratory Disease
Blood Disorder	Gastrointestinal	Liver Disease	Stroke
Back Problems	Heart Murmur	Low Blood pressure	Tuberculosis
Breathing Problems	Heart Disease	Mental/Nervous Disorder	Ulcers
Cancer/Chemo	Hepatitis A-B-C	Migraines	Venereal Disease

Other: _____

Are you allergic to, or have you reacted adversely to any of the following: (Please Check)

Latex_____	Sulfa Drugs_____
Penicillin_____	Barbituates, Sedatives or Sleeping Pills_____
Local Anesthetic (Novocaine)_____	Aspirin_____
Codeine or other Narcotics_____	Other_____

Women: Are you pregnant? Yes/No Birth Control? Yes/No Are you Nursing? Yes/No

Have you ever been hospitalized? Yes/No If yes for what reason?_____

Please list **ALL** medications you are taking at this time:_____

_____

_____

Recent Surgeries and Date: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for which I am entitled. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Print Name _____

Signature_____ Date_____

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. 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 4/15/03, 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 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

We use and disclose health information about your treatment, payment, and healthcare operations. For example:

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 provided 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 is 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 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 if (including identifying or locating) a family member, your personal representative or another person responsible for your care, or 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 interferences 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 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.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign this Acknowledgment

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

- May we phone, email, or send a text to you to confirm appointments? Yes / No
- May we leave a message on your answering machine at home or on your cell phone? Yes / No
- May we discuss your dental conditions with any member of your family? Yes / No

If Yes, please list the family members allowed and their relation to you:

_____

_____

_____

_____

Please Print Name_____

Signature _____

Date_____