OAKPORT DENTAL NEW PATIENT PAPERWORK

PATIENT INFORMATION

Today's Date: _____ How did you hear about our office? _____

First Name:_____ MI:_____ Last Name:_____

Street Address: _____ City: _____

ST: _____Zip code: _____ Driver License Number: _____

Date of Birth: _____SSN: _____Email: _____

Mobile Phone Number: _____Work Phone Number: _____

Emergency Contact Person: _____ Phone Number: _____

RESPONSIBLE PARTY: Are you the responsible party for this account? Yes or No

If no, list a responsible party: _____

Relationship to patient: _____ Street Address:_____

City: _____ State: _____ Zip code: _____ Phone number: _____

INSURANCE INFORMATION:

Insurance Name: _____ Insurance phone number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Street Address: _____ City: _____

ST: _____ Zip Code: _____ Phone Number: _____

Member ID: _____ Group Number: _____

PHARMACY INFORMATION:

Pharmacy Name: _____ Pharmacy Phone Number: _____

Street Address: _____City:_____ ST:_____ Zip Code:_____

Patient Signature or Resposible Party Signature: _____

NEXT PAGE

OAKPORT DENTAL MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____
Are you under a physician's care now? **Y** or **N**: _____
Have you ever been hospitalized or had a major operation? **Y** or **N**_____
Have you ever had a serious head or neck injury? **Y** or **N** _____
Are you on a special diet? **Y** or **N**
Do you use tobacco? **Y** or **N**
Do you use controlled substances? **Y** or **N**
WOMEN: Are you pregnant/ Trying to get pregnant? **Y** or **N Nursing: Y** or **N**
ALLERGIES: Aspirin ___ Penicillin ____ Codeine ___ Acrylic __ Metal __ Latex __
Sulfa Drugs __ Local Anesthetics: __ Other: _____
List all medications:

_____

Do you have, or have you had any of the following? Please CIRCLE

None	Cortisone Medicine	Hepatitis A	Scarlet Fever
Aids/HIV positive	Diabetes	Hepatitis B or C	Shingles
Alzheimer's Disease	Drug Addiction	Herpes	Sickle Cell Disease
Anaphylaxis	Easily Winded	High Blood Pressure	Sinus Trouble
Anemia	Emphysema	High Cholesterol	Spina Bifida
Angina	Epilepsy/Seizures	Hives or Rash	Stomach/Intestinal
Arthritis	Excessive Bleeding	Hypoglycemia	Stroke
Artificial Heart Valve	Excessive Thirst	Irregular Heartbeat	Swelling of Limbs
Artificial Joint	Fainting Spell/Dizzy	Kidney Problems	Thyroid Disease
Asthma	Frequent Cough	Leukemia	Tonsillitis
Blood Disease	Frequent Diarrhea	Liver Disease	Tuberculosis
Blood Transfusion	Frequent Headaches	Mitral Valve Prolapse	Tumors or Growths
Breathing Problems	Genital Herpes	Osteoporosis	Ulcers
Bruise Easily	Glaucoma	Pain in Jaw Joints	Venereal Disease
Cancer	Hay Fever	Parathyroid Disease	Yellow Jaundice
Chemotherapy	Heart Attack/Failure	Psychiatric Care	
Chest Pains	Heart Murmur	Radiation Treatments	
Cold Sores/ Blisters	Heart Pacemaker	Recent Weight Loss	
Congenital Heart	Heart Disease	Renal Dialysis	
Convulsions	Hemophilia	Rheumatic Fever	

OTHER: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

PATIENT SIGNATURE: _____ DATE: _____

NEXT PAGE

OAKPORT DENTAL

FINANCIAL AGREEMENT

I hereby agree that payment is due when services are rendered, unless a prior arrangement has been made. I understand that unpaid balances will be considered delinquent after 30 days, and in default after 45 days; after which interest will be charged at a rate of 1 ½ percent per month on the unpaid balance(annual rate of 18% or the legal interest rate, whichever is lower).In the event of a legal suit or collections actions to enforce payment of the unpaid balance, I agree to pay such attorney fees, count costs and / or collection fees , as deemed reasonable. I waive venue jurisdiction and submit myself to the jurisdiction and venue of the Courts of Seminole County, State of Florida.

Patient Signature: _____ **Date:** _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to be made directly to Oakport Dental Sanford PLLC, or other agent of their choosing for benefits that may be due and payable under the insurance coverage for myself and / or my co-insurers. I authorize utilization of this application or copies thereof for the purpose of processing claims and affecting payments. **YOUR TREATMENT PLAN GIVEN IS AN ESTIMATE ONLY.WE CANNOT GUARANTEE THE AMOUNT OF YOUR INSURANCE BENEFITS.** Therefore, I further acknowledge that this agreement of benefits does not in any way relieve me of liability, and that I remain financially responsible to Oakport Dental Sanford PLLC for any fees unpaid by any insurance or dental plan.

Patient Signature: _____ **Date:** _____

MISSED APPOINTMENTS

I understand that time is set aside for me, and it is my obligation to keep scheduled appointments. **I FURTHER UNDERSTAND THAT UNLESS 2 BUSINESS DAYS ADVANCE NOTICE ID GIVEN, I WILL BE LIABLE TO PAY A $50 BROKEN APPOINTMENT FEE FOR EVERY HOUR I HAVE SCHEDULED.**

Patient Signature: _____ **Date:** _____

PAYMENT OPTIONS: Cash, check, care credit, and all forms of credit/debit cards

NEXT PAGE

Oakport Dental Sanford PLLC

2421 S. Maple Avenue
Sanford, Florida 32771

{NAME OF PRACTICE}

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 4/14/03, 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 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

We use and disclose health information about you for 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 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 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 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.

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, 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 $0.___ for each page, $___ per hour for staff time to 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 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 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, 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.

Contact Officer: _____

Telephone: (407)323-5340 Fax: _____

E-mail: Sanford@oakfortdental.com

Address: _____

Oakport Dental Sanford PLLC
2421 S. Maple Avenue
Sanford, Florida 32771

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES
OAKPORT DENTAL
2421 S MAPLE AVE
SANFORD, FL 32771
(407) 323-5340

I _____ hereby acknowledge that I have received and reviewed a copy of Oakport Dental Sanford's HIPAA Notice of Privacy Practices.

I understand that Oakport Dental Sanford's HIPAA Notice of Privacy Practices may change periodically , and that I am entitled to receive a copy of Oakport Dental Sanford's revised HIPAA Notice of Privacy Practices upon request.

I understand that if I have questions about Oakport Dental Sanford's HIPAA Notice of Privacy Practices, I may contact Dr. Craig Aebli.

I understand that it is my right to refuse to sign this Acknowledgment should I so choose, and that Oakport Dental Sanford will not refuse treatment to me if I refuse to sign this Acknowledgment. I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Oakport Dental Sanford's privacy policies and procedures. For information on how to contact the U.S Department of Health and Human Services, please ask front office, noted above, for assistance.

PATIENT SIGNATURE: _____ DATE: _____

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

PRINT NAME OF PERSONAL REPRESENTATIVE: _____

RELATIONSHIP OF PERSONAL REPRESENTATIVE TO PATIENT: _____

FOR OFFICE USE ONLY
Oakport Dental Sanford made a good-faith effort to obtain Acknowledgment from the patient noted above, of receipt of its HIPPA Notice Privacy Practices. In spite of these efforts, Oakport Dental Sanford was unable to obtain a signed Acknowledgment for the following reason(s):

__ Refusal to sign Acknowledgment on _____, 20____

__ Communication barriers prohibited us from obtaining a signed Acknowleddgement.

__ An emergency situation prohibted us from obtaining a signed Acknowledgement.

__ Other (Describe): _____

Date Received: _____ By: _____ Patient ID: _____

NEXT PAGE

OAKPORT DENTAL SLEEP SCALE QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Male:___ Female:___ Weight: _____ Height: _____

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS

Have you been diagnosed with sleep apnea?	Yes or No
Do you wear a C-PAP while sleeping?	Yes or No
Do you feel sleepy or fatigued during the day?	Yes or No
Do you feel the need to take a nap to make it through the day?	Yes or No
Do you stop breathing, gasp, or choke while asleep?	Yes or No
Do you snore?	Yes or No
Do you have high blood pressure?	Yes or No

HOW LIKELY ARE YOU TO FALL ASLEEP IN THE FOLLOWING SITUATIONS?
CHOOSE THE APPROPRIATE NUMBER FOR EACH SITUATIONS

0-NEVER/ 1-SLIGHT CHANCE/ 2-MODERATE CHANCE/ 3- HIGH CHANCE

While sitting and reading ___
Watching TV ___
Public places (movies, meetings, Etc.) ___
Passenger in car ___
Lying down to rest ___
Sitting ___
Sitting quietly after lunch ___
Stopped in traffic for a few minutes ___