Pebblebrooke DENTISTRY

Full Name _____ Nickname _____

Date of Birth _____ SSN: _____ Gender: Male/Female

Family Status: Married/ Single/ Child/ Other Email Address _____

Address _____

Street City, State Zip Code

Home Phone (____) _____–_____ Cell Phone (____) _____–_____ Other (____) _____–_____

How did you hear about us?

_____

Preferred Pharmacy _____

Medical History

What is the approximate date of your last medical exam _____

Please list all of your treating physicians, their specialty, and phone number:

_____

_____

_____

Have you been hospitalized within the last 2 years due to a surgery or illness? If yes, please explain:

_____

_____

MEDICATIONS "Y"= You are taking or have taken the medication ☐ Not taking any of these medications

Bone Medications	Y	N	Blood Thinners	Y	N	Other	Y	N
Actonel/ Atelvia			Aspirin			Embrel (etanercept)		
Boniva (ibandronate)			Coumadin (warfarin)			Xgeva (denosumab)		
Fosamax (alendronate)			Eliquis (apixaban)			Birth Control Pills		
Prolia (denosumab)			Pradaxa (dabigatran)			NOTE: Antibiotics may alter the effectiveness of birth control pills. Consult with your physician for guidance regarding additional methods of birth control.		
Reclast (zoledronate)			Savaysa (edoxaban)					
Aredia (pamidronate)			Xarelto (rivaroxaban)					
Zometa (zoledronate)			Other Blood Thinner					

Please list any current medications that you are taking other than those listed above:

☐ Medication List Provided **(We can scan a list if you have it)**

_____

_____

Please list any vitamins/supplements that you are taking:

_____

Do you have any artificial joints? Metal rods, pins, or screws? If yes, please explain and list treating Doctor:

_____

Have you ever been told that you need to take an antibiotic prior to dental treatment/cleanings?

_____

Pebblebrooke DENTISTRY

Please indicate if you are allergic to any of the following: □ NO KNOWN DRUG ALLERGIES

□ Penicillin □ Codeine □ Aspirin □ Metal □ Motrin (Ibuprofen)

□ Latex □ Local Anesthetic □ Epinephrine □ Sulfa □ Acetaminophen(Tylenol)

□ Casein □ Other: _____

Please indicate if you have experienced any of the below conditions. Please elaborate and/or provide dates of surgeries, etc:

o Anemia _____
o Arthritis _____
o Aspirin Therapy _____
o Auto Immune Disease _____
o Blood Thinners _____
o Currently Pregnant _____
o Diabetes: Last A1C? _____
o Epilepsy _____
o Excessive Bleeding _____
o Fainting _____
o Glaucoma _____
o Gluten Allergy _____
o Head/Neck Injuries _____
o Heart Disease _____
o Heart Murmur _____
o High Blood Pressure _____
o HIV/AIDS _____
o Kidney Disease _____
o Mental Disorders _____
o Osteoporosis Meds _____
o Radiation Treatment _____
o Seasonal Allergies _____
o Stroke _____
o Thyroid Disease _____
o Ulcers/Cold Sores/Fever Blisters _____
o Vertigo _____
o Heart Stents _____

o Alzheimer's _____
o Artificial Joints _____
o Atrial Fibrillation (AFib)_____
o Blood Disease _____
o Cancer _____
o Chemotherapy _____
o Dizziness _____
o Down Syndrome _____
o Hepatitis A _____
o Hepatitis B _____
o Hepatitis C _____
o Herpes _____
o Jaundice _____
o Liver Disease _____
o Low Blood Pressure _____
o Mitral Valve Prolapse _____
o Nervous Disorders _____
o Pacemaker_____
o Pre-Medication _____
o Respiratory Problems _____
o Rheumatic Fever _____
o Sinus Problems _____
o Stomach Problems _____
o Tuberculosis _____
o Tumors _____
o High Cholesterol _____

Please list any other illnesses you may have that are not listed above:

_____

_____

Are you interested in Botox treatment? □ Yes □ No

Pebblebrooke DENTISTRY

Dental History

What was the approximate date of your last dental visit? _____

What was performed? _____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

Reason for your visit today:

_____

How frequently do you brush your teeth? _____ Floss? _____

Do you use an electric toothbrush? □ Yes □ No

Do you use a Waterpik or other water flosser? □ Yes □ No

Do your gums bleed when you brush or floss? □ Yes □ No

Do your teeth experience sensitivity to hot or cold temperatures? □ Yes □ No

Do any of your teeth experience sensitivity to sweets? □ Yes □ No

Are any of your teeth currently causing you pain? □ Yes □ No

Do you grind your teeth? □ Yes □ No

Do you currently wear a nightguard? □ Yes □ No

Do you experience jaw pain? □ Yes □ No

Do you experience jaw joint clicking or popping? □ Yes □ No

Have you ever had trouble getting numb during a procedure? □ Yes □ No

Do you have a history of periodontal treatment? □ Yes □ No

Are any of your teeth loose? □ Yes □ No

Do you have a history of oral cancer? □ Yes □ No

Do you currently use tobacco? □ Cigarettes □ Cigars □ Pipes □ Chewing Tobacco

Do you currently use recreational drugs? □ Yes □ No

Do you regularly consume alcohol? □ Yes □ No

Do you experience dry mouth? □ Yes □ No

Do you chew ice? □ Yes □ No

Do you bite your fingernails? □ Yes □ No

Do you have a medical issue preventing you from lying back all the way? □ Yes □ No

Are you fearful of dental treatment? (Please rate 1–10)

□ No Fear □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ Very Fearful

Pebblebrooke
DENTISTRY

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail. I hereby certify that I have read and understand the previous information, and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and that I may be billed for this remaining balance. I consent and agree fully to be financially responsible for payment of all services rendered on my behalf, or on behalf of my dependents (if any). There is a $15 monthly late fee that will be applied to any past due balances. It is my responsibility to pay this balance, as the services were rendered to me by Dr. Campos.

_____

Signature of Patient, Parent, or Guardian Date

We are so excited to have you as a part of our Pebblebrooke Dentistry family. Dr. Campos and team strive to render exceptional dental care to our patients. In order to do so, Dr. Campos expects the following from her patients. If you have concerns with any of the procedures listed below, please discuss these with Dr. Campos.

For COMPREHENSIVE new patients: a new Full Mouth Series of x-rays will be required on every new patient. New and current radiographs are vital in providing you with a current diagnosis of your oral health.

For existing patients: Evaluations at every 6 month appointment, Bitewing x-rays once every year, Full Mouth x-rays every 3 years, additional single xrays may be required annually if we are keeping an eye on a specific tooth

_____

Signature of Patient, Parent, or Guardian Date

Pebblebrooke DENTISTRY

PLEASE READ CAREFULLY AND COMPLETE THIS FORM IF YOU HAVE DENTAL INSURANCE

Due to changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

Our office does not participate with any insurance networks (we are out-of-network with all dental plans). If your plan allows you to choose any provider you wish (PPO), then you can use your benefits in our office. However, since we are an out-of-network provider, it is not possible for us to know exactly how much your insurance will pay. We can only estimate based on the insurance information that is provided to us. Please remember that your insurance policy is a contract between you and your insurance company, not with your doctor.

We will be happy to file your insurance claim for you. You will pay for your treatment in full, and have your insurance company reimburse you directly. This is our preferred method as it prevents billing, and is a very direct and hassle-free approach.

I understand Pebblebrooke Dentistry's insurance policy that is stated above. I also understand that if I do not pay in full at the time of service, I may receive a statement for any remaining balance not covered by my insurance company. It is my responsibility to pay this balance, as the services were rendered to me by Dr. Campos.

_____ _____

Signature of Patient, Parent, or Guardian Date

_____

Relationship to Patient

Dental Insurance Information (Please provide dental insurance card if you have it)

Insurance Company _____

Insurance Company Phone Number _____

Insurance Claims Address: _____

Policy Holder: _____ Policy Holder Birthdate: _____

Member ID _____ Group Number: _____

Appointment Policy

Dear Patient,

Here at Pebblebrooke Dentistry, we strive to render excellent dental care to you, your family, and all of our patients. In order to be consistent with this philosophy, we use an appointment system that sets aside ample time for a patient dependent on the patient's current needs. Our office hours are by appointment, and we value your time. This office is a private practice dental office, and not a dental "clinic." Appointments are reserved for you alone. Like many offices, we do try to contact you to confirm your appointment. Please do not depend on this courtesy. If you cannot make an appointment as scheduled, please notify our office. There will be a charge of $50 for any missed appointments, or any appointments cancelled or rescheduled without 48 hours' notice. (This amount is subject to change depending on the amount of time we have reserved for you.) Chronic missed appointments/late cancellations will result in dismissal from the practice. We do understand that extreme or unavoidable emergencies or circumstances do arise and individual circumstances will be taken into consideration. We also know that delays can happen, however we must try to keep our patients and doctor on time to the appointments we have scheduled for the day. Any patients who arrive more than 15 minutes late to their appointment may be rescheduled. This policy helps ensure that everyone is seen in a timely manner and helps to reduce wait times. We appreciate your understanding and patronage in this matter. If you have any questions or concerns regarding this policy, please feel free to ask us!

I have read and understand Pebblebrooke Dentistry's Appointment Policy, and agree to be bound by its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

NOTICE OF PRIVACY PRACTICES
EFFECTIVE JANUARY 1, 2026

THIS NOTICE DESCRIBES HOW MEDICAL 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 MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION
For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.
Privacy Officer: Courtney Short
Telephone: (239) 348-7383
Address: 14255 Collier Blvd, Suite 100, Naples, FL 34119

OUR LEGAL DUTY
We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information.
We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices.
We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION
Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.
Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.
Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.
Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorize, you may opt out of these communications at any time.

Family, Friends and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement.

We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email and telephone. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). If you prefer that we NOT leave a message to confirm treatment or your appointments, please check this box. ☐

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

- for public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
- to avert a serious an imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1) HIV/AIDS;
2) Mental Health;
3) Genetic Tests (in accordance with GINA 2009);
4) Alcohol and drug abuse;
5) Sexually transmitted diseases and reproductive health information; and
6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

1) You have a right to see and get a copy of your health records.
2) You have a right to amend your health information.
3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.

5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile. If you would like to opt out of this level of service, you may do so by checking this box. ☐
6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
7) You have a right to restrict who receives your information.
8) You have a right to request amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
9) If you believe your rights are being denied or your health information is not being protected, you can:
    a. File a complaint with your provider or health insurer
    b. File a complaint with the U.S. Government

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint. You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office for Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

I, _____, have received and understand the practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practice.

Your signature below hereby acknowledges that you have reviewed our Notice of Privacy Practices document and understand that you may obtain a copy for your records upon request.

Signature _____ Date _____

Pebblebrooke
DENTISTRY

Authorization to Release Information

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the result of dental procedures, treatment plans, procedures, test results, and financial information, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/ dental information, appointment information, any diagnostic test results, referral information, and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This Authorization to Release Information will remain in effect until you provide us with an updated Release form with changes.

I authorize Pebblebrooke Dentistry to release my records and any information requested to the following individuals:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____
5. _____ Relation to Patient: _____

_____ _____

Patient Signature (Signature of Patient, Parent, or Guardian) Date

_____

Printed Name