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 medicaitons

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 Fibrulation _____
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

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).

_____

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: _____

Pebblebrooke DENTISTRY

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

Pebblebrooke DENTISTRY

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on August 5, 2013 and remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the change. Before we make significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any change in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Courtney Short. Information on contacting us can be found at the end of this notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use and disclose your heath information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of heath information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or I you are an inmate or otherwise under custody of the 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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury, and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

Signature On Back →

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards, or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our privacy officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1 for each page and the staff time charged will be $25 per hour including the time required to locate a copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer or a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an example of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on August 5, 2013. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2014, the disclosure period would start on August 5, 2013 up to May 15, 2014. Disclosures prior to August 5, 2013 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing, Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Pebblebrooke Dentistry
Privacy Officer: Courtney Short
Telephone: (239) 348-7383
Address: 14255 Collier Blvd, Suite 100, Naples, FL 34119

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 HIPAA 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