Lifetime Smiles Dental Care

Christopher M. Donato D.M.D.
& Associates

Welcome, so we may provide you with the best possible care and get to know you better; please complete this Medical & Dental History Form. Please keep in mind that all information is kept Confidential.

Date: _____

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr. Preferred Name: _____

Name: _____
First Middle Initial Last

Address: _____
City State Zip

Home Phone: _____ Cell: _____

Work: _____ Email: _____

Marital Status: _____ Social Security #: _____ / _____ / _____
SOCIAL SECURITY NUMBERS ARE REQUIRED FOR ALL INSURANCE CLAIM SUBMISSIONS.

Sex: Male or Female D.O.B.: _____ / _____ / _____

Insurance Information / Legal Guardian Information

Please fill this section out using the subscriber's/ legal guardian info.

Insured Person's Name: _____ D.O.B.: _____ / _____ / _____

Employer's Name: _____ Social Security#: _____/ _____ / _____
SOCIAL SECURITY NUMBERS ARE REQUIRED FOR ALL INSURANCE CLAIM SUBMISSIONS.

Insurance Company: _____ Group #: _____

Employment Information

Employer: _____ Occupation: _____

How did you hear about us?

Yellow Pages ( ) Walk-In ( ) Mailer: Postcard ( ) /Coupon ( )

Internet Search ( ) Insurance ( ) _____ Other ( ) _____
Company

Employee / Friend ( ) _____
Name of Patient or Person that referred you

Medical History

Patient Name: _____

Primary Care Physician: _____ Telephone: _____

Pharmacy: _____ Telephone: _____

Primary Diagnosis: _____

Please indicate the appropriate response by circling Yes or No:
If yes please elaborate . . .

Yes No Have you been under the care of a medical doctor in the past TWO years?

_____

Yes No Have you ever been hospitalized or had a major operation? Any sedation history?

_____

Yes No Have you ever had a serious head or neck injury?

_____

Yes No Have you ever had a reaction to a local anesthetic or sedation?

_____

Yes No Have you ever been told to Pre-Medicate with Antibiotics prior to Dental Appointments?

_____

Yes No Have you ever taken any of the following (circle if yes)?
Phen-fen, Redux, Fosamax, Boniva, Actonel or any other medicines containing biphosphonates?

Yes No Do you use tobacco?

WOMEN:
Are you Pregnant? Yes No
Trying to get pregnant? Yes No
Nursing? Yes No
Taking oral contraceptives? Yes No

Yes No Are you Allergic to any of the following (circle):
ASPIRIN PENICILLIN CODEINE ACRYLIC METAL LATEX
SULFA DRUGS LOCAL ANESTHETICS OTHER_____

Yes No Do you use controlled substances?

Please List all Current Medications:

_____

_____

_____

_____

Doctor's Initials: _____

Patient Name: _____

Medical History Continued . . .

Please indicate the appropriate response by circling, Yes or No:

Do you have, or have you had, any of the following . . .

AIDS/HIV	Yes	No	Hemophilia	Yes	No
Alzheimer's	Yes	No	Hepatitis A ( ) B ( ) C ( )	Yes	No
Anaphylaxis	Yes	No	Herpes	Yes	No
Anemia	Yes	No	High Blood Pressure	Yes	No
Angina	Yes	No	High Cholesterol	Yes	No
Arthritis/Gout	Yes	No	Hives or Rash	Yes	No
Artificial Heart Valve	Yes	No	Hypoglycemia	Yes	No
Artificial Joints	Yes	No	Irregular Heartbeat	Yes	No
Asthma	Yes	No	Kidney Problems/Trouble	Yes	No
Blood Disease	Yes	No	Leukemia	Yes	No
Blood Transfusion	Yes	No	Liver Disease	Yes	No
Breathing Problems	Yes	No	Low Blood Pressure	Yes	No
Bruise Easily	Yes	No	Lung Disease	Yes	No
Cancer	Yes	No	Mitral Valve Prolapse	Yes	No
Chemotherapy	Yes	No	Osteoporosis	Yes	No
Chest Pains	Yes	No	Pain in Jaw Joints	Yes	No
Cold Sores/Fever Blisters	Yes	No	Parathyroid Disease	Yes	No
Congenital Heart Disorder	Yes	No	Psychiatric Care	Yes	No
Convulsions	Yes	No	Radiation Treatment	Yes	No
Cortisone Medicine	Yes	No	Recent weight loss	Yes	No
Diabetes	Yes	No	Renal Dialysis	Yes	No
Drug Addiction	Yes	No	Rheumatic Fever	Yes	No
Easily Winded	Yes	No	Rheumatism	Yes	No
Emphysema	Yes	No	Scarlet Fever	Yes	No
Epilepsy/Seizure	Yes	No	Shingles	Yes	No
Excessive Bleeding	Yes	No	Sickle Cell Disease	Yes	No
Excessive Thirst	Yes	No	Sinus Trouble	Yes	No
Fainting/Dizziness	Yes	No	Spina Bifida	Yes	No
Frequent Cough	Yes	No	Stomach/Intestinal Disease	Yes	No
Frequent Diarrhea	Yes	No	Stroke	Yes	No
Frequent Headaches	Yes	No	Swelling of limbs	Yes	No
Genital Herpes	Yes	No	Thyroid Disease	Yes	No
Glaucoma	Yes	No	Tonsillitis	Yes	No
Hay Fever	Yes	No	Tuberculosis	Yes	No
Heart Attack/Failure	Yes	No	Tumors or Growths	Yes	No
Heart Murmur	Yes	No	Ulcers	Yes	No
Heart Pace Maker	Yes	No	Venereal Disease	Yes	No
Heart Trouble/Disease	Yes	No	Yellow Jaundice	Yes	No
Heart Valve (Artificial)	Yes	No			

Comments or any additional information:

_____

_____

_____

_____

Doctor's Initials: _____

Patient Name: _____

Dental History . . .

Are you currently having any Dental Problems at this time? _____

When was your last Dental Appointment? _____

Date of Last Cleaning: _____ Date of Last X-rays: _____

Previous Dentist: _____
Name Location Phone #

What didn't you like about your previous office? _____

How often do you:

Brush _____ **Floss** _____ **Whiten** _____

See your Hygienist for cleanings? _____

Have you ever been told/treated for Periodontal Disease? Yes No Date: _____

What dental products are you using at home? _____

Are your teeth Sensitive to:

Heat: Yes No **Cold:** Yes No **Sweets:** Yes No **Biting:** Yes No

Do you notice?

Bleeding upon brushing?	Yes	No	Gum Recession?	Yes	No
Swelling of the Gum Tissue?	Yes	No	Bad Breath/Taste?	Yes	No
Frequent Headaches	Yes	No	Loose Teeth	Yes	No

Discomfort/Popping/Clicking of your Jaw? Yes No

Grinding or Clenching of your teeth? Yes No

Do you have a Night Guard? Yes No

On a Scale of 1-10 how would you rate your:

Smile: _____ Dental Health: _____

Would you like your teeth: Whiter: Yes No Straighter: Yes No

If you could change one thing about your smile what would it be?

_____

What can we do to make your visit more comfortable?

_____

Privacy Notice and Consent

Lifetime Smiles Dental Care, Christopher M. Donato and Associates; believes our patients have the right to Privacy and that their personal financial and health information should be kept confidential. Our belief in your right to privacy is nothing new. However, new laws now require that we notify you about our privacy in writing.

How do we use your personal health information?

We will use your personal health information to provide, coordinate, or manage your dental treatment and any related services. This may include providing necessary information to pharmacy personal, laboratory technicians, or to third party health care providers. For example, we might need to disclose information, as necessary, to a home health agency that provides care to you, or to a physician or dental specialist to whom you have been referred to ensure that they have the necessary information to diagnose or treat you.

Personal information may be given to your insurance company if necessary to facilitate payment of your claims.

On occasion your personal information may be used for/in supporting the practices business operations. These activates include, but are not limited to, quality assessments activities, employee review activities, training of dental students, licensing, and conductions or arranging for other business activities. We may use a sign-in sheet at the receptionist desk where you will be asked to sign your name and indicate the practitioner you are to see. We may also call you by name in the reception area when ready to bring you back. We may use or disclose your protected health information, as necessary; to contact you to remind you of your appointment or discuss any questions we may have regarding your account.

We may also use or disclose your personal information in the following situations without your authorization as required by law: Public health issues/communicable diseases, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners request, research, criminal activity, national security, and workers compensation.

What are your rights?

- You have the right to inspect and copy your personal information
- You have the right to request a restriction of your personal information.
    - This means you may ask us not to use or disclose any of your personal information for the purposes of treatment, payment, or operations.
    - You may also request that any part of your information not be disclosed to family members or friends who may be involved in your care or for that notification purposes as described in this Notice of Privacy Practices.
        - Your request must state the specific restriction requested, in writing, and to whom you want the restriction to apply.
- Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit the use and disclose of such information, it will not be restricted. You then have the right to use another Health Care Professional.
- You have the right to request/receive confidential communications from us by alternative means or at an alternative location.
- You may have the right to have your dentist amend your personal health information
- You have the right to receive an accounting of certain disclosures we have made, if any, of your personal health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object of withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You can be assured there will be no ill-will following a complaint by you.
This notice was published and becomes effective on/before December 10, 2010.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected personal/health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number (813) 872-7909.

This is to certify that I have read and understand the above information. By signing this statement, I am giving Lifetime Smiles Dental Care, Christopher M. Donato and Associates and its team member's permission to release my personal information as described above.

_____ _____

Signature of Patient / Legal Guardian Date

Office and Financial Policy

Welcome and thank you for choosing Lifetime Smiles for all your Dental needs. We are committed to providing you with the highest quality of dental care, in an efficient, timely, and cost effective manner. We hope that by providing you with our policies in advance you will have a great experience with our office and gain a better understanding of the financial obligation related to your dental treatment.

Treatment Plan

We have prepared for you an itemized Treatment Plan that outlines the sequence of dental services to be provided. The Treatment Plan reflects the clinical findings and standard of care procedures dentally necessary for you to attain the smile and overall dental health you are seeking. Due to the nature of dentistry, treatment and fees may change; if this occurs will inform you prior to rendering any services.

Estimated Fees

The Treatment Plan has an estimation of what we *expect* your insurance carrier to pay. Each insurance benefit plan is slightly different in its covered services; it is the insurance carrier's discretion for final payment. If you have any questions on your insurance coverage, please feel free to contact your insurance company or your Employer's Human Resources Department.

We understand that your insurance carrier may deny, adjust, or pay an alternate benefit; so as a courtesy to you, we will send a bill for the amount due. Your insurance carrier will provide an explanation of benefits. There may be a balance due after your claim is processed by your insurance carrier. As the policy holder and account guarantor, you are responsible for all fees not paid by your insurance carrier.

Insurance Benefits

As the insurance holder, you are responsible for knowing your insurance benefits and coverage. As a courtesy to you, we will accept the insurance assignment of benefit. We will gladly file your insurance claim on your behalf. Please note that in order to submit and process insurance claims appropriately, we must have social security numbers for both the patient and the policy holder. We will allow 30 days from the date of service for the insurance company to pay. If the insurance carrier does not pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage/benefits (i.e. deductibles, non-covered services, co-insurance, pre-existing conditions, reasonable and customary charges, etc.) You are responsible for the timely payment of your account.

Payment Types

Payment of fees is due at the time services are rendered. For your connivance, we accept Cash, Personal Checks (with Identification), Visa, MasterCard, Discover, Amex, Care Credit, and Lending Club. **There is a $25 fee for all returned checks.**

Payment Plan and Financing Options

As convenience for you, we have made arrangements with Third-Party Healthcare Lenders to provide a financing option that will allow you to pay for your dental care over an extended period of time. This option is based on Approval. Please ask our Financial Specialist how you can apply.

No Shows and Cancellation Policy

24 hours notice is required for all cancellations. Each Patient is allowed ONE no show or cancellation without 24hours notice without penalty. Any additional broken appointments will result in a $35 charge to your account. Hospital Appointments are not subject to the regular cancellation policy. 48 hours' notice is required to cancel any Hospital Appointment; otherwise a $250 cancellation fee will be charged to the account.

Non-Payment Recourse and Disclosure

As a courtesy we do not charge interest on accounts until your account is outstanding past 90 days. Any balances unresolved and outstanding past 90 days will be charged a $10 monthly billing fee unless prior arrangements have been made. If no contact or payments are made the account will be sent to an Attorney or Collection Agency. A collection fee of 33% for balances less than 1 year; and 50% for balances over 1 year will be added to your account.

I have read, understand, and have agreed to the above office and financial policies. I hereby attest that I have given and agree to provide current personal, demographic, and insurance information and authorize release of information necessary to fill insurance and or collection of my account.

_____ _____

Signature of Patient / Legal Guardian Date

Lifetime Smiles Dental Care

Christopher M. Donato D.M.D.
& Associates

HIPAA Disclosure Form

Patient Name: _____ Date of Birth: ___/____/____

Authorizing Parent/ Guardian: _____

Address: _____

_____

Phone Number: (____) _____-_____

Alt. Phone Number: (____) _____-_____

E-mail address: _____@_____

May we identify ourselves over the phone? ☐ YES ☐ NO

May we leave messages? ☐ YES ☐ NO

Do you opt for text messages correspondence? ☐ YES ☐ NO

Do you opt for e-mail correspondence? ☐ YES ☐ NO

I, the Patient or authorized parent/guardian, hereby allow Lifetime Smiles Dental Care and its affiliates to discuss, transfer and/or release my medical and dental information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, prescriptions, etc.) via postal mail, telephone, fax, and/or e-mail to the following persons:

Name: _____ DOB: ___/____/_____ Relationship: _____

Name: _____ DOB: ___/____/_____ Relationship: _____

Name: _____ DOB: ___/____/_____ Relationship: _____

Name: _____ DOB: ___/____/_____ Relationship: _____

_____ _____

Signature Date