PATIENT INFORMATION

Last name: _____First_____ Middle_____

Address: _____City_____ Zip_____

SSN _____ Date of Birth_____

For insurance information: please **circle t**he following: Full Time, Part time, Retired, Student

Home Phone: _____Work phone_____

Cell Phone: _____Email Address: _____

Spouse/ Partner Last name _____First _____

Person Financially responsible for this account: _____

Your Employer _____Spouse _____

Insurance Information

Insurance company: _____ Phone: _____

Name Insurance Policy is in: _____Employer: _____

Identification Number: _____ Group Number _____

Secondary Insurance: _____Phone: _____

Name Secondary Insurance is in: _____Employer: _____

Identification Number: _____ Group Number _____

How did you become aware of our office: _____

Financial Policy: Payment in full for services performed is due at the time of service, unless other arrangements have been made prior to the appointment. For your convenience, our office accepts cash, personal check, Visa, MasterCard and Discover. We will file your primary insurance for you. You will be responsible for your estimated portion at the time of service. ANY PORTION, WHICH YOUR INSURANCE DOES NOT PAY, FOR WHATEVER REASON, YOU ARE RESPONSIBLE FOR AND IS DUE WITHIN 10 DAYS AFTER RECEIVING YOUR STATEMENT. If payment is not received after the first statement, subsequent statements will include a $10 Billing Charge. Any costs incurred for collection or legal fees are the responsibility of the patient and/or responsible party.

Patient (or Guardian) Signature: _____Date:_____

We ask that you give at least 24 hour notice of any change in your appointments. Please review our Broken Appointment Policy.

Pat info 08/07

Patient Name _____
Medical Alert _____

DENTAL HISTORY

So that we may provide you with the best possible care please complete both sides of the medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No
If yes, please describe: _____

Date of last Dental Visit _____ last Dental Cleaning _____ last Full Mouth x-rays _____

What was done at your last dental visit? _____

Did any previous dentist recommend dental treatment that was never performed? Yes No

If yes, what type of work was it? _____

Why was this treatment never performed? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Rotodent, Interplak, toothpick, etc.) _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesion?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught between any teeth?	Yes	No

If yes, where? _____

Do you:

Clench/grind teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No
Do you feel nervous about dental treatment?	Yes	No
Ever had an upsetting dental experience?	Yes	No

If so, please describe _____

_____

Have you ever had:

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty chewing on either side of mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Please **Circle** the following dental values **most important** to you and **Underline** the **least important**:
Esthetics Comfort Longevity Function
Long-term cost effectiveness

Please Circle the most important feature(s) in your smile that you would like to change? Color Shape Alignment Length Gaps Gum display Nothing, I'm Happy
Other _____

Would you like your smile analyzed? Yes No
If yes, is there a spouse or significant other you want to include in our discussion? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe_____

MEDICAL HISTORY

Patient Name	Health Alert	BP:

1. Have you been under the care of a medical doctor during the past 2 years? . . . Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____

2. Have you taken any medication/drugs during the past 2 years? . . . . . Yes No

3. Are you taking any medication, drugs, or pills now? . . . . . Yes No
   If yes, please list name and dosage: _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?
   If yes, please list:_____ . Yes No

5. Have you been a patient in the hospital during the past 5 years? . . . . . Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Tuberculosis	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A , B, or C	Yes	No
Asthma	Yes	No	Swollen Ankles	Yes	No	Venereal Disease	Yes	No
Taken Fen-Phen	Yes	No	Stroke	Yes	No	AIDS	Yes	No
Latex Sensitivity	Yes	No	Artificial Joints (hip, knee)	Yes	No	HIV Positive	Yes	No
Allergies/Hives	Yes	No	Kidney Trouble	Yes	No	Cold Sores/Fever Blisters	Yes	No
Sinus Trouble	Yes	No	Thyroid Problems	Yes	No	Blood Transfusion	Yes	No
Heart(Surgery/Disease/Attack)	Yes	No	Ulcers	Yes	No	Hemophilia	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Sickle Cell Disease	Yes	No
Congenital Heart Disease	Yes	No	Glaucoma	Yes	No	Bruise Easily	Yes	No
Heart Murmur	Yes	No	Emphysema	Yes	No	Liver Disease	Yes	No
High Blood Pressure	Yes	No	Chronic Cough	Yes	No	Yellow Jaundice	Yes	No
Mitral Valve Prolapse	Yes	No	Radiation Therapy	Yes	No	Neurological Disorders	Yes	No
Artificial Heart Valve	Yes	No	Chemotherapy	Yes	No	Epilepsy or Seizures	Yes	No
Heart Pacemaker	Yes	No	Tumors	Yes	No	Fainting or Dizzy Spells	Yes	No
Rheumatic Fever	Yes	No	Pace Maker	Yes	No	Nervous/Anxious	Yes	No
Arthritis/Rheumatism	Yes	No	Hearing Impaired	Yes	No	Psychiatric (Psychological Care)	Yes	No

7. Do you use more than two pillows to sleep? . . . . . Yes No

8. Have you lost or gained more than 10 pounds in the last year? . . . . Yes No

9. Do you have or have you had any disease condition, or problem not listed above? Yes No
   If yes, please list: _____

10. **Women** Are you: Pregnant? Yes, _____Months No **Nursing** Yes No

I understand the above information is necessary to provide me with dental care in a safe & efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.
In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs & reasonable attorney fees as may be required to effect collection of this note

Patient/Guardian Signature _____ Date _____ med 08/07

History Review

Doctor Signature Date

JAMES S. BEGLEY, DDS, PA
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 14, 2003

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. However, we reserve the right not to agree to the requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. A reasonable copying charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
    - is not part of your medical or billing records;
    - is not available for inspection as set forth above; or
    - is accurate and complete.

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment and health care operations as provided above;
    - to persons involved in your care or for other notification purposes as provided by law;
    - to correctional institutions or law enforcement officials as provided by law;
    - for national security or intelligence purposes;
    - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
    - incidental to other permissible uses or disclosures;
    - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
    - made to patient or their personal representatives;
    - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

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HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

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OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Barry Watson, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at James S. Begley, DDS, PA or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

James S. Begley, DDS. PA
Barry Watson – Privacy Officer
29605 US 19 North, Suite 120
Clearwater, FL 33761
Tel: (727) 787-3811
http://www.drbegley.com

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.

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James S. Begley, DDS, PA

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID #:** _______________________

I hereby acknowledge that I have received a copy of Dr. James Begley's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

I give permission to share my dental records with:____________________________________

____

____

____

________________________________ ____________________________________
Signature of Patient Date

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

______________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____

____

____

____

____

- ☐ Other (Specify)

____

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