PATIENT NAME	____________	**TODAY'S DATE**	____________
HOME ADDRESS	____________	**DATE OF BIRTH**	____________
	____________	**HOME PHONE**	____________
E-MAIL	____________	**CELL PHONE**	____________
EMPLOYER	____________	**BUSINESS PHONE**	____________
INSURANCE CO.	____________	**SS#/SIN**	____________

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN ____________ OFFICE PHONE ____________ DATE OF LAST EXAM ____________

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ____________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use alcohol, cocaine or other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg. novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin or other antibiotics	☐	☐	Sedatives	☐	☐	Other ____________
☐	☐	Sulfa Drugs	☐	☐	Iodine			____________

9. WOMEN ONLY:	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐

11. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies
☐	☐	Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low/High Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other ____________
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	____________

COMMENTS

____

____

____

____

____

Signature of Dentist ____________ Date

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	YES	NO
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X ____________ ____________

PATIENT, PARENT OR GUARDIAN — DATE

CONFIDENTIAL

Patient Registration Information

Date ______________________

Name ____ Patient # ______________
First Mi Last

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

Home address ____________________ City ____________________ State/Prov. ________ Zip/P.C. __________

Birthdate ______________ Home Phone ____________________ Work Phone ____________________

E-Mail ____________________________________ Cell Phone ____________________

Do you prefer to receive calls at: ☐ Work ☐ Home ☐ Either

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your or your parent/guardian's employer ______________________ Occupation ______________

Business address ____________________ City ______________ State/ Prov. __________ Zip/ P.C. __________

Spouse or parent/guardian's name ____________ Employer ____________________ Work phone __________

If you are a student, name of school/college ______________ City ______________ State/ Prov. __________

Whom may we thank for referring you? ____

Person to contact in case of an emergency ______________________________ Phone __________

Responsible Party

Name of person responsible for this account ____________________ Relationship ______________

Address ____ Home Phone ______________

City ____________________ State/ Prov. ____________ Zip/ P.C. ________ SS #/SIN ______________

Driver's license # ____________________ Birthdate __________ Financial institution ______________

E-Mail ____________________________________ Cell Phone ____________________

Employer ____ Work phone ______________

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of insured ____

Relationship to patient ____

Birthdate ________________ SS #/SIN ____________________ Date employed ______________

Employer ____ Work phone ______________

Address of employer ________________ City ______________ State/ Prov. __________ Zip/ P.C. __________

Insurance company ____________________ Group # ______________ Employer/cert. # ____________

Ins. co. address ____________________ City ______________ State/ Prov. __________ Zip/ P.C. __________

How much is your deductible? __________ How much have you used? __________ Max. annual benefit? __________

Please Continue... ☞

Additional Insurance

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured ______________________________

Relationship to patient ______________________________

Birthdate ______________ SS #/SIN ______________ Date employed ______________

Employer ______________________________ Work phone ______________

Address of employer ______________ City ______________ State/ Prov. ______________ Zip/ P.C. ______________

Insurance company ______________ Group # ______________ Employer/cert. # ______________

Ins. co. address ______________ City ______________ State/ Prov. ______________ Zip/ P.C. ______________

How much is your deductible? __________ How much have you used? __________ Max. annual benefit? __________

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actucl bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X ______________________________ ______________

Signature of patient or parent/guardian if minor Date

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

______ Cash

______ Personal Check

______ Credit Card ______ Visa ______ MasterCard

Card # ______________________________ Expiration Date __________

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

Item 053-0311/9053 Patterson Office Supplies 800-637-1140

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 April 14, 2003, 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 $0.95 for each page, $30.00 per hour for staff time to locate and 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: Mitchell Indictor DDS

Telephone: (561)734-8600 Fax: (561) 738-6672

E-mail: info@EastBoyntonDental.com

Address: 207 SE 23rd Avenue, Suite 100, Boynton Beach, Florida 33435-7653

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

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East Boynton Dental
MITCHELL INDICTOR, D.D.S.
FAMILY AND IMPLANT DENTISTRY

Notice to our Patients

APPOINTMENT POLICY

Appointments are made specifically for each patient and that time is reserved for you. Our office policy requires at least 24 hours notice if you cannot keep that appointment.

When you cancel an appointment in advance, it allows us to contact other patients who may be waiting for an appointment time.

If you cancel an appointment with less tha 24 hours notice, or if you just do not come in for your schedules appointment, we are unable to use that time for anyone else.

The office policy, as of 01/01/2006, is to charge a fee for late cancellations or missed appointments. While some other offices may charge the full session fee for the appointment, our fee is $50.00.

We are issuing this notice as a reminder to you-PLEASE make it a point to record your appointment time.

Our preference is that you keep the appointment.

If you cannot keep it, please call in advance to change it.

We do not want you to have to pay a fee, and this also enables us to accommodate another patient's need for an appointment.

Thank you, in advance, for understanding and cooperation.

____

Signature Date

MASTER, ACADEMY OF GENERAL DENTISTRY
FELLOW, INTERNATIONAL CONGRESS OF ORAL IMPLANTOLOGISTS
www.eastboyntondental.com
mindictorddspa@bellsouth.net

207 S.E. 23RD AVENUE
BOYNTON BEACH, FLORIDA 33435
Ph: (561) 734-8600
Fax: (561) 738-6672

EAST BOYNTON DENTAL
Mitchell Indictor D.D.S., P.A.
207 SE 23rd Avenue
Boynton Beach, Fl 33435
561-734-8600

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE DENTAL INSURANCE, WE ARE ANXIOUS TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. IN ORDER TO ACHIEVE THESE GOALS, WE NEED YOUR UNDERSTANDING OF OUR PAYMENT POLICY.

PAYMENT FOR SERVICES IS DUE AT THE TIME THE SERVICES ARE RENDERED UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY OUR STAFF. WE ACCEPT CASH, CHECKS. MASTERCARD, VISA AND CARE CREDIT. WE WILL BE HAPPY TO HELP YOU PROCESS YOUR INSURANCE CLAIM FOR REIMBURSEMENT FOR NON-PARTICIPATING PLANS. WE WILL PROCESS ALL FORMS FOR PARTICIPATING INSURANCE COMPANIES WHERE WE ACCEPT ASSIGNMENT OF BENEFITS. IN SOME INSTANCES, SOME INSURANCE COMPANIES REQUIRE THAT YOU BRING IN A SPECIFIC INSURANCE FORM WHICH MUST BE COMPLETELY FILLED OUT AND SIGNED BY THE MEMBER FOR REIMBURSEMENT.

RETURNED CHECKS AND BALANCES OLDER THAN 30 DAYS MAY BE SUBJECT TO ADDITIONAL COLLECTION FEES AND INTEREST CHARGES. CHARGES MAY ALSO BE INCURRED FOR BROKEN AND CANCELLED APPOINTMENTS WITHOUT 24 HOUR ADVANCE NOTICE.

WE WILL GLADLY DISCUSS YOUR PROPOSED TREATMENT AND ANSWER ANY QUESTIONS RELATING TO YOUR INSURANCE BEFORE ANY TREATMENT BEGINS, HOWEVER:

1. YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPNAY.
2. MOST INSURANCE COMPANIES PAY ON A PERCENTAGE BASIS, SUCH AS 100% FOR PREVENTATIVE, 80% FOR BASIC, AND 50% FOR MAJOR SERVICES. YOU, THE MEMBER WILL THEN BE RESPONSIBLE FOR ANY DEDUCTIBLE, OR COINSURANCE UP TO 100% OF THE MAXIMUM ALLOWABLE FEE SET FORTH BY YOUR INSURANCE COMPANY.
3. OTHER INSURANCE COMPANIES PAY ON A FLAT FEE SCHEDULE WHEREAS DEDUCTIBLES AND COPAYS MAY STILL APPLY AND WOULD BE THE MEMBERS RESPONSIBILITY.

4. NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS. OUR OFFICE CANNOT BE RESPONSIBLE TO KNOW ALL ASPECTS OF YOUR PLAN. THIS IS THE RESPONSIBILITY OF THE MEMBER. ANY SERVICES NOT COVERED WILL BE THE PATIENTS TOTAL RESPONSIBILITY.

WE MUST EMPHASIZE THAT AS DENTAL CARE PROVIDERS, OUR RELATIONSHIP IS WITH YOU AND NOT THE INSURANCE COMPANY. WE REALIZE TEMPORARY FINANCIAL PROBLEMS MAY EFFECT TIMELY PAYMENT OF YOUR ACCOUNT. IF SUCH PROBLEMS DO ARISE, WE ENCOURAGE YOU TO CONTACT US PROMPTLY FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACCOUNT.

IF YOU HAVE ANY QUESTIONS ABOUT INFORMATION, OR ANY UNCERTAINTY REGARDING YOUR INSURANCE COVERAGE, PLEASE DO NOT HESITATE TO ASK. OUR STAFF IS HERE TO HELP YOU.

I UNDERSTAND AND AGREE THAT, (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ABOVE, AND FULLY UNDERSTAND MY RESPONSIBILITES.

IF AGREED FEES ARE NOT PAID IN FULL, PATIENT WILL BE RESPONSIBLE FOR AN ADDITIONAL 33 1/3% CHARGE, ON ANY REMAINING BALANCES, TO COVER ALL COLLECTION, ATTORNEYS AND COURT FEES.

______________________________/______________________________

PATIENTS NAME (PLEASE PRINT) PATIENT/ GUARDIAN SIGNATURE

ADDRESS____

DOB______________ SS#______________________________________

(of responsible party)

TOTAL FEE$_____________ SIGNATURE OF RESPONSIBLE PARTY

X______________________________