Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. No. _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle _____ MARITAL STATUS _____

RESIDENCE Street _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS? _____ Cell _____ HOME PHONE _____ WORK PHONE _____

EMAIL _____

SOCIAL SECURITY NO. _____ BIRTHDATE _____ DRIVER'S LICENSE NO. _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
(LAST) (FIRST) (MIDDLE)

EMPLOYER _____ NO. YEARS EMPLOYED _____

OCCUPATION _____ SOC. SEC. NO. _____

WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

NAME _____

ADDRESS _____

CITY, STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. No. _____ Group No. _____ Local No. _____

If you have double insurance coverage, complete this section for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. No. _____ Group No. _____ Local No. _____

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

	YES	NO
HOW LONG SINCE you have seen a Dentist? _____		
Date of Last ***COMPLETE*** Dental Exam _____		
Date of Last ***FULL MOUTH X-RAYS:*** _____ (16 small Films or Panoramic)		
Are you having ***PROBLEMS*** now?	☐	☐
WHAT? _____		
Is your present dental health ***POOR?***	☐	☐
Do you wear ***DENTURES?*** (Partials or Full)	☐	☐
Are you ***UNHAPPY*** with your dentures?	☐	☐
Would you like to know more about ***PERMANENT REPLACEMENTS?***	☐	☐
Are you ***APPREHENSIVE*** about dental treatment?	☐	☐
Have you had any ***PERIODONTAL (GUM)*** treatments?	☐	☐
Do your gums ***BLEED,*** feel ***TENDER*** or become ***IRRITATED?***	☐	☐
Are your teeth ***SENSITIVE*** to hot, cold, sweets, pressure? (circle)	☐	☐
Are you ***UNHAPPY*** with the ***APPEARANCE*** of your teeth?	☐	☐
Are you aware of ***GRINDING*** or ***CLENCHING*** your teeth?	☐	☐
Do you have ***HEADACHES, EARACHES,*** or ***NECK PAINS?***	☐	☐
Have you worn ***BRACES*** on your teeth? ***(ORTHODONTICS)***	☐	☐
Do you have ***DISCOLORED*** teeth that bother you?	☐	☐
Would you like your smile to ***LOOK BETTER*** or ***DIFFERENT?***	☐	☐
Do you ***REGULARLY*** use ***DENTAL FLOSS?***	☐	☐

Name of Previous Dentist: _____

City: _____ State _____

How do you feel about your teeth? _____

Please ***RANK*** the following in the order in which they would ***KEEP YOU FROM*** having dental treatment.

FEAR of pain # _____ ***LACK*** of concern # _____

COST of treatment # _____ ***MISSING*** work time # _____

MEDICAL HISTORY

	YES	NO
Do you have any ***CURRENT HEALTH PROBLEMS?***	☐	☐
Are you under a ***PHYSICIAN'S CARE*** now?	☐	☐
For What? _____		
What ***MEDICATIONS*** are you currently taking? _____		
Are you ***PREGNANT?***	☐	☐
Do you ***SMOKE?***	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	AIDS/ARC/HIV Pos.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (Hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Venereal Disease	Alcoholism
Ulcers	(Syphilis, Gonorrhea, etc.)	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin

Please list any other medications or substances you are allergic to? _____

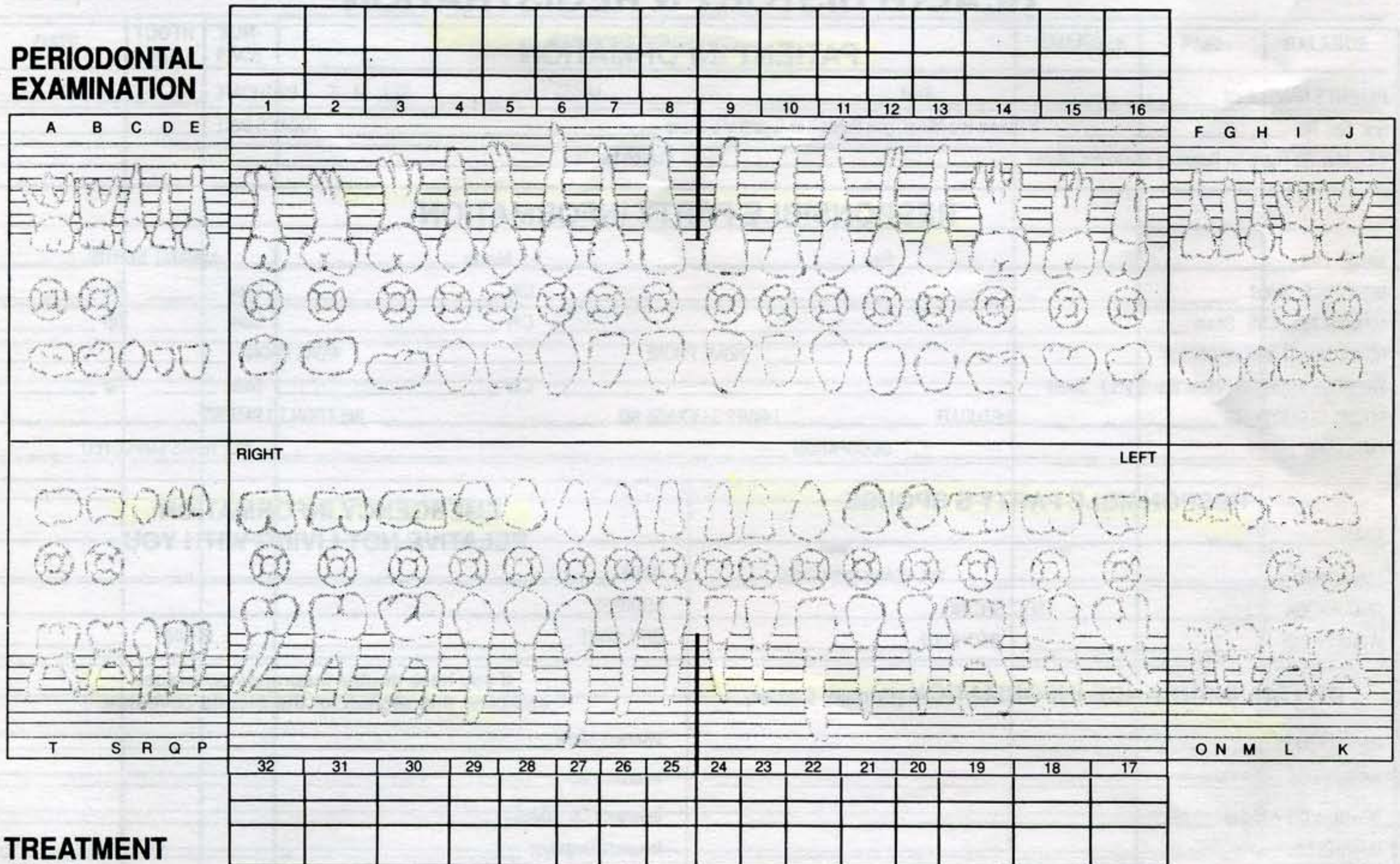
Please list any other Medical or Dental information you feel we should know about: _____

FAMILY PHYSICIAN _____ PHONE NO. _____

PATIENT Signature (Parent of Child) _____ Date _____ DENTIST Signature _____

DIAGNOSIS: MISSING TEETH and EXISTING PROBLEMS

PERIODONTAL EXAMINATION

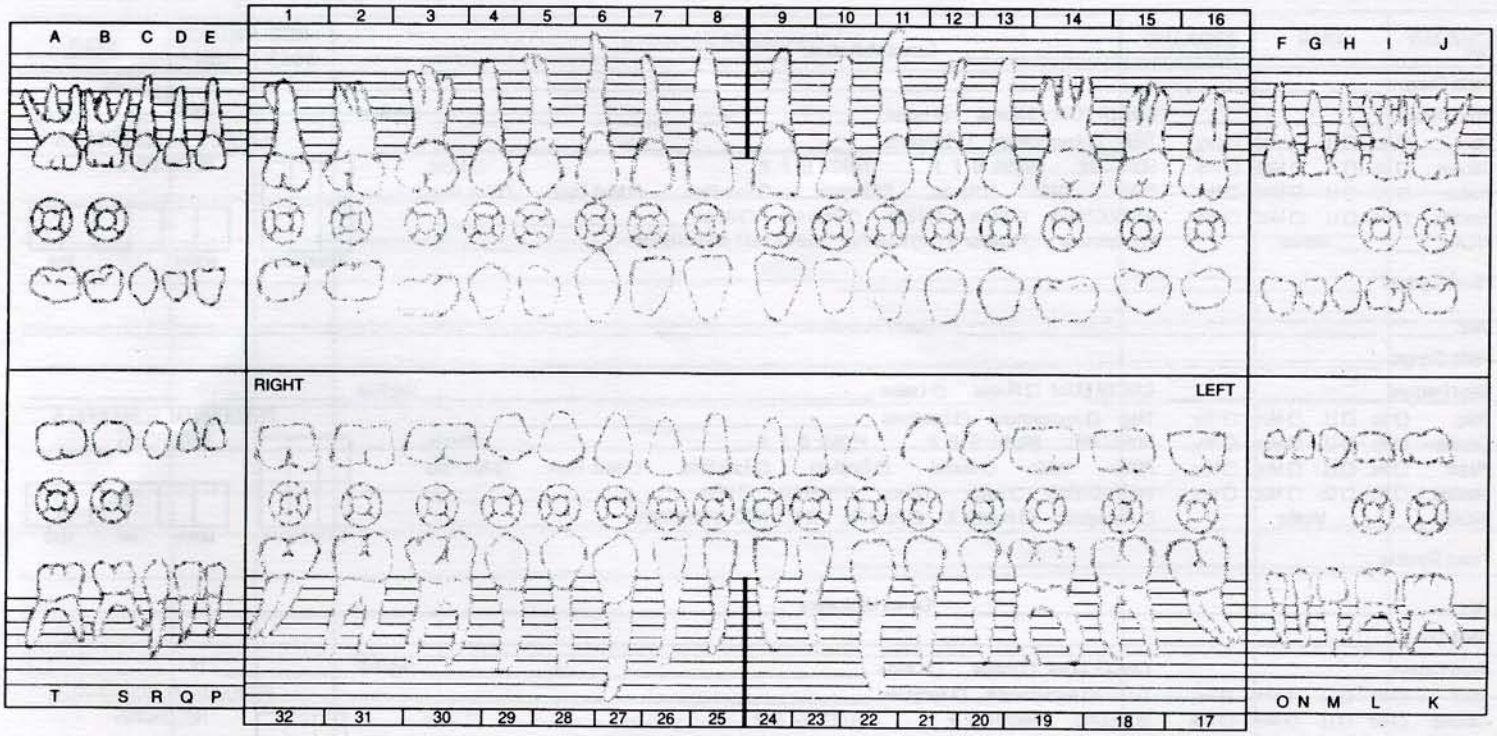


TREATMENT PLAN

DATE DIAGNOSED	TOOTH NO.	SURFACE	DESCRIPTION OF SERVICE	ADA CODE	FEE	CO-PAY
			EXAMINATION			
			X-RAY: PANORAMIC: FMX: BWX:			
			DIAGNOSTIC MODELS			
			PROPHYLAXIS (CLEANING)			
			QUADRANTS SCALING & CURETTAGE			
			NITROUS OXIDE GAS			

DATE DIAGNOSED	TOOTH NO.	SURFACE	DESCRIPTION OF SERVICE	ADA CODE	FEE	CO-PAY

COMPLETED TREATMENT



INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMMATION:	❒ Slight	❒ Moderate	❒ Severe
SOFT PLAQUE BUILDUP:	❒ Slight	❒ Moderate	❒ Heavy
HARD CALC. BUILDUP:	❒ Light	❒ Moderate	❒ Heavy
STAINS:	❒ Light	❒ Moderate	❒ Heavy
HOME CARE EFFECTIVENESS:	❒ Good	❒ Fair	❒ Poor
PERIODONTAL CONDITION:	❒ Good	❒ Fair	❒ Poor
PERIODONTAL DIAGNOSIS:	❒ Normal	❒ Gingivitis	
PERIODONTITIS:	❒ Early	❒ Moderate	❒ Advanced

MUCOGINGIVAL DEFECTS #s: _____

CLINICAL DATA:

OCCLUSION: ❒ Class I ❒ Class II ❒ Class III ❒ Crossbite: _____

T.M.J. EXAM: ❒ Normal ❒ Popping ❒ Deviation ❒ Tooth Wear ❒ Pain

INITIAL SOFT TISSUE EXAM:

❒ Lips ❒ Floor of Mouth ❒ Palate ❒ Tongue ❒ Neck & Nodes

PATIENT'S TREATMENT DECISIONS:

❒ DOCUMENTATION OF DENTAL RECORD COMPLETED

❒ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)

❒ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ❒ FM-PAS ❒ BWX ❒ PANO ❒ OTHER _____

❒ NO BONE LOSS

❒ SLIGHT BONE LOSS (04600)

❒ **MODERATE BONE LOSS (04700)**

❒ MAJOR BONE LOSS (04800)

❒ **BEGINNING FURCATION (04700)**

❒ ADVANCED FURCATION (04800)

❒ OTHER: _____

QUADRANTS

UR	UL	LR	LL

SHADE

Teeth	Upper	Lower
Cents		
Lats		
Cusp		
Posts		

SEXTANT SCORE

PERIODONTAL SCREENING & RECORDING

MONTH DAY YEAR

EXISTING PROSTHESIS:

MAX. _____ DATE PLACED: _____ CONDITION: _____

MAND. _____ DATE PLACED: _____ CONDITION: _____

REFERRALS:

PERIO: _____ ORTHO: _____ ENDO: _____

ORAL SURG: _____ M.D. _____ OTHER: _____

NOTES

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

PATIENT Signature (Parent of Child) _____ Date _____ DENTIST Signature _____

I understand that where appropriate, credit reports may be obtained.

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are please to discuss fees with you any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask I you have any questions about our fees, Financial Policy, or your financial responsibilities.

All patients must complete and sign our "Patient Registration Forms" completely before seeing the doctor.

FULL PAYMENT IS DUE AT THE START OF TREATMENT.

NO POST-DATED CHECKS WILL BE ACCEPTED.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD & AMERICAN EXPRESS. Please note that a 3.5% surcharge is imposed on all credit card payments. No surcharge is applied on debit cards.

REGARDING INSURANCE

PPO/TRADITIONAL INSURANCE – I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the Doctor. Therefore, I am still responsible for all dental fees. As a courtesy to me, Everlasting Smiles is submitting all claims to my insurance company on my behalf. However, my patient's portion is expected in full at the time services are rendered unless prior arrangements have been made. I am also assigning all insurance benefits (payments) to the Doctor. Any payments received by the doctor from my insurance coverage will be credited to my account or refunded to me if I have already paid all dental fees incurred. Please note that insurance payments are paid based on an estimated percentage and any unpaid charges from the insurance company for services performed also becomes the patient's responsibility. I further understand that a late charge will be added to any overdue balance after 30 days.

MINOR

The adult accompanying a minor, and his/her parents (or guardians), is responsible for full payments at the time of service. For unaccompanied Minors non-emergency treatment will be denied unless charges have been pre-authorized by parents at the time of service.

MISSED APPOINTMENTS

We will make every effort to arrange appointments that fit into our schedule. We do ask that you kindly give us **48 hours'** notice should an emergency prevent you form keeping your appointment to avoid a BROKEN APPOINTMENT CHARGE ($70) ADDED TO YOUR ACCOUNT. This will also allow us to accommodate other patients in need of treatment. Should you habitually miss appointments, we reserve the right to dismiss you from our practice.

COLLECTION POLICY

If for any reason, there is a balance on your account that has not been paid after **90 days:** your balance will be forwarded to our collection agency (Capital Accounts). At that time, you will be responsible for the collection fee of (30% of outstanding balance) and the balance owed to the office.

Thank you for understanding our Financial Policy. Please let us know if your have any questions or concerns.

RESPONSIBLE PARTY SIGNATURE_____**DATE**_____

William Ma D.M.D
4397 Northlake Blvd Ste 202
Palm Beach Gardens, Fl 33410
561-622-8013

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members, allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date_____

Relationship to patient: _____
(If signed by a personal representative of patient)