PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ PREFERED NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ WORK #: _____ CELL #: _____ EMAIL: _____

BIRTH DATE: _____ SOC. SEC.: _____ DRIVERS LIC: _____

IN CASE OF EMERGENCY PLEASE CONTACT: _____ PHONE NUMBER: _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

IF PATIENT IS MINOR, OR SOMEONE BESIDES THE PATIENT IS RESPONSIBLE PARTY, PLEASE FILL OUT FOLLOWING:

FIRST NAME: _____ LAST NAME: _____ IF ADDRESS IS THE SAME CHECK HERE ☐

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ WORK #: _____ CELL #: _____ EMAIL: _____

BIRTH DATE: _____ SOC. SEC: _____ DRIVERS LIC: _____ _____

DENTAL INSURANCE

NAME OF INSURED: _____ INSURED BIRTH DATE: _____ _RELATIONSHIP TO INSURED: _____

INSURED SOC. SEC: _____ SUBSCRIBER ID: _____ GROUP#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURED EMPLOYER: _____ INSURANCE COMPANY: _____ INSURANCE PHONE: _____

IF THERE IS SECONDARY INSURANCE, PLEASE PUT INFORMATION HERE: _____

MEDICAL HISTORY

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURETELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES TO PERSONAL INFORMATION AND MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ **DATE:** _____

Dr. Michael P Costabile, DMD PA
Dental Associates of Boca Raton

2404 Wilton Drive Wilton Manors, FL 33305
Ph: (954)440-7795 Fax: (954)440-7971

INFORMED CONSENT

PLEASE READ CAREFULLY:

"The mission of Dental Associates of Boca Raton is to help improve the oral health and dental education of the community. To create a practice dedicated to quality patient care. We are committed to the utmost in care and compassion. We strive to provide access to oral care in a comforting and comprehensive atmosphere; including being at the forefront of technology and having a skillful staff in a synergistic atmosphere that encourages both, patients and staff, to be excited about dentistry."

-Dr. Costabile

1. YOUR HEALTH:
I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medications, allergies or illnesses may compromise my dental treatment.

I understand that latex gloves, antibiotics, local anesthetics and other medications can cause allergic reactions. I have informed Dental Associates of Boca Raton of any known allergies.

I am aware that certain heart conditions and having artificial joints may require pre-medication before starting any dental procedure. I have informed Dental Associates of Boca Raton if I need to be pre-medicated before dental procedures.

I understand that some antibiotics may interfere with birth control pills.

I am aware that Epinephrine in local anesthetic may cause a temporary increase in heart rate. Oral anesthesia may cause bruising and temporary numbness of the lips, cheeks, tongue or other facial tissues. In rare cases, this condition may be permanent.

2. YOUR VISIT:
Florida State Dental Board's regulations require that all new patients undergo a complete dental examination along with a full series of x-rays and periodontal (gum) evaluation.

I understand that if I would like to address a specific concern, a limited problem focused examination will be performed and a complete oral examination will be done at the doctor's discretion.

I understand that gum disease may prevent me from having "just a cleaning." I understand that routine cleanings are not the appropriate treatment for gum disease and other procedures may be necessary.

I agree to have Dr. Costabile and licensed/registered staff to examine and evaluate my dental and oral condition.

3. YOUR TREATMENT:
I understand that I may have to undergo treatment deemed necessary for dental conditions as diagnosed by the doctor.

I understand that dental treatment may include, but is not limited to: fillings, crowns, bridges, dentures, extractions, impacted tooth removal, root canals, bone grafts, implants, treatment of periodontal disease or "deep cleanings", orthodontic treatment, cosmetic veneers, teeth whitening, etc.

I am aware that some teeth that require fillings or crowns may require unanticipated root canals at the time of treatment or, in some cases, after treatment is done.

I understand there may be changes to my treatment plan as seen necessary by the doctor. I am aware that certain conditions may not have been evident at the time of examination and may be discovered during treatment. Additional services may need to be added to my treatment plan.

I understand that, in dentistry, no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment.

4. YOUR OFFICE:
I understand that Dental Associates of Boca Raton will file insurance claims on my behalf as a courtesy to me. I am aware that not all procedures recommended are covered by dental insurance.

I understand that my insurance coverage is my responsibility to carry and understand. I agree to let the office know of any changes in coverage BEFORE my appointment otherwise I may have to pay out of pocket or have my appointment canceled. (a broken appointment fee may apply)

I understand that insurance coverage and co-payment quoted is only an estimate and not a guarantee of payment on their behalf. I agree to be financially responsible for all charges incurred.

I agree to pay for services at the time services are rendered. I understand this includes insurance co-payments and private payments; unless previous financial arrangements have been made.

I am aware Dental Associates of Boca Raton may require a pre-payment towards treatment if appointment is 2 hours or more in length.

I agree to arrive on time for my scheduled dental appointments to allow adequate time for treatment. I understand that arriving more than 15 minutes may result in losing the appointment and a broken appointment fee may apply.

I understand that in order to cancel an appointment I must give at least 48 hours notice. If I fail to give proper cancellation notice, a broken appointment fee may apply.

I am aware that Dental Associates of Boca Raton will forgive the first occurrence of this policy as a courtesy to me. I understand that if I continue to fail and break appointments, I will have to pre-pay for treatment in full in order to schedule future appointments or I may forfeit the privilege to schedule future appointments.

I understand the office uses text messaging for appointment reminders, billing and confirmations. I agree to accept such messaging and to confirm my appointments. Unconfirmed appointments are automatically canceled.

I am aware that in some cases photos may be taken of my teeth before and after treatment, with no distinguishable recognition of my full-face or likeness (unless approved) may be used by the office for dental records, research, training and marketing purposes. I understand that there is no compensation for the use of my photographs. By initialing here _____ I remove consent to use my full-face photos. (This means that only photos of your teeth, jaw and mouth will be used)

CONSENT: I have been given the opportunity to have all my questions answered. My signature below signifies that I understand this informed consent put forth by Dental Associates of Boca Raton.

Patient or Guardian's Signature _____ Date _____

Notice of Privacy Practices for Protected Health Information

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!

With your consent, this practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Your protected health information may be shared with other medical professionals or specialists that may be involved in your treatment. It may also be shared with your insurance provider for payment processing purposes. In some cases, your health information may shared with our insurers or other business associates for the purpose of quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written
- request to our office; File a statement of disagreement if your amendment is denied, and require that the request for
- amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact **our office,** in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

This practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and
- maintain about you; Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office.
Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr. Costabile. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature Date

Dental Associates of Boca Raton

2404 Wilton Drive Wilton
Manors, FL 33305
www.mybocasmile.com

I, _____, give permission to Dental Associates of Boca Raton and its payers to disclose and release my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

- ☐ Only the information needed to create, cancel, or modify appointments
- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify) _____
    _____

My health information may be used to enable the individuals listed above to know and understand my condition and my treatment or treatment options, for treatment consultations, for claims, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, **OR**
- ☐ Date or event:_____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date