## Patient Information

**Patient Name**: _____ Date: _____
Last, First MI (Preferred Name)

**Address**: _____
Street Apartment #

_____
City State Zip Code

**Employer:** _____ **Occupation**: _____

**Family Status:** Married…Divorced…Single…Child…Other _____

**Social Security #** _____ **Birth Date**: ____/____/____ **Gender:** Male / Female

**Phone** Home: _____ Work: _____ Ext: _____ Cell: _____

Fax: _____ Other: _____ E-mail Address: _____

## Seasonal Patients

2nd Address: _____
Street Apartment #

_____
City State Zip Code

Dates at 2nd address: From _____ to _____

Do you have a northern dentist? Circle: Yes No

## Spouse, Parent or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the patient's parent/guardian ☐ the person responsible for payment ☐ Male ☐ Female

Name: _____ Employer: _____

Social Security #: _____ Birth Date: _____

Phone Home: _____ Work: _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Should insurance deny coverage for any treatment provided by this office, the patient agrees to pay any remaining unpaid balance.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

**Whom may we thank for referring you to our practice?** ☐Another Patient, Friend ☐ Another Patient, Relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Insurance ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

# MEDICAL HISTORY

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

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart (Surgery, Disease, Attack) | Yes | No | Emphysema…… | Yes | No | Cold Sores…… | Yes | No |
| Chest Pain …… | Yes | No | Chronic Cough…… | Yes | No | Fever Blisters…… | Yes | No |
| Congenital Heart Disease.. | Yes | No | Cancer…… | Yes | No | Blood Transfusion…… | Yes | No |
| **Heart Murmur**…… | Yes | No | Tuberculosis …… | Yes | No | Hemophilia…… | Yes | No |
| High Blood Pressure…… | Yes | No | Asthma …… | Yes | No | Sickle Cell Disease…….. | Yes | No |
| **Mitral Valve Prolapse**…… | Yes | No | **Sleep Apnea**……. . | Yes | No | Liver Disease…… | Yes | No |
| **Artificial Heart Valve**……. | Yes | No | **Latex Sensitivity** …….. | Yes | No | Neurological Disorders… | Yes | No |
| **Heart Stent/Shunt**…… | Yes | No | Allergies or Hives …… | Yes | No | Epilepsy or Seizures…… | Yes | No |
| **Heart Pacemaker**…… | Yes | No | Radiation Therapy……. | Yes | No | Fainting or Dizzy Spells.. | Yes | No |
| **Rheumatic Fever**…… | Yes | No | Chemotherapy…… | Yes | No | Nervous/Anxious…….. | Yes | No |
| Arthritis/Rheumatism…….. | Yes | No | Tumors…… | Yes | No | Psychiatric Care…… | Yes | No |
| Stroke…… | Yes | No | Hepatitis A (Infectious). | Yes | No | Sinus Trouble……... | Yes | No |
| **Artificial Joints**…… | Yes | No | Hepatitis B (Serum)…... | Yes | No | **Allergy to Jewelry**……. | Yes | No |
| Kidney Trouble…… | Yes | No | Venereal Disease…….. | Yes | No | **Allergy to Metal**……... | Yes | No |
| Diabetes…… | Yes | No | A.I.D.S.…… | Yes | No | **TMJ Disorder**…….. | Yes | No |
| Thyroid Problems…… | Yes | No | H.I.V. Positive…… | Yes | No | Smoke / Chew Tobacco.. | Yes | No |

Have you been prescribed a C-Pap device? Yes No
If yes, do you currently use it? _____

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

Are you under the care of a physician? Yes No
If yes, please explain _____
Name of physician _____

Are you taking any medication, drugs or pills now? Yes No
If yes, please list: _____
_____

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

**Women**

Are you: **Pregnant?** Yes _____Months No **Nursing?** Yes No **Taking Birth Control Pills?** Yes No

**Pharmacy Name**: _____ **Phone Number**: _____

**Pharmacy Address**: _____

I understand the above information is necessary to provide me with dental care in a safe and 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 hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of **(Name of Patient)** _____**'s** dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks; I understand that I can ask for a complete recital of any possible complications.

**Signature** _____ **Date** _____ **Witness** _____

**Parent or Responsible Party** _____ **Relationship to Patient** _____

**Statement of Privacy Notice**
**This notice describes how medical information about you may be used and disclosed.**
**Please review the information carefully.**

The office of Melanie Pugh, DMD, PA is a structured as an organized healthcare arrangement, which allows for the sharing of protected health information among groups and services listed in this notice to carry out services for treatment, payment, or healthcare operations.

Your protected health information may be released to other healthcare professionals for the purpose of providing you with quality healthcare. We may share your health information to assist in coordinating the care you need, such as prescriptions, digital, images, or other diagnostic tests. Your protected health information may be released to your insurance provider for the purpose of our office to receive payment for providing you with the needed healthcare services. Your protected health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, crime or domestic violence. Your protected health information may be released to other healthcare providers in the event you need emergency care. Your protected health information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective devise. You may revoke your permission to release protected health information at any time. It must be in writing with effective date and be specific to the health information being protected. Melanie Pugh, DMD, PA is not required to agree to your request. Your protected health information may be disclosed to an approved research project in accordance with our policy and protocol for protecting the patient's privacy. In most cases, Melanie Pugh, DMD, PA will have the opportunity to obtain your authorization before any information is shared.

You may be contacted by our office by phone or mail (or leave a message on an automated answering device) to remind you of appointments, pre-scheduled procedures, verify your insurance or inform you of information we have received from your insurance company. You have the right to request a more confidential way of providing your protected health information or alternative communication method. We will honor all reasonable requests. You have the right to restrict the use of your protected health information. However, Melanie Pugh DMD, PA may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation. You have the right to receive confidential communication about your health status. We might disclose health information to notify, or assist in the notification (Including identifying or locating) a family member, your personal representative or another person responsible for your care, your location or your general condition. We will also use our professional judgment and our experience with common practice to make responsible decisions when releasing your health care. You have the right to a photocopy of any portions of your health information; our office has the right to assess a fee for the photocopying of the health information. You have the right to request an amendment to your health information. It must be in writing and explain why the information should be amended. Melanie Pugh DMD, PA can deny the amendment. You have the right to possess a copy of this Statement of Privacy Notice upon request. Melanie Pugh DMD, PA is required by law to protect the privacy of its patients. We will keep protected any and all patient health information.

You have the right to complain to the office of Melanie Pugh DMD, PA if you believe your rights to privacy have been violated. If you feel your right have been violated,
Please mail a written complaint to:

**Melanie Pugh DMD, PA**
**Attn: Privacy Officer**
**8800 Bernwood Parkway #4**
**Bonita Springs, FL 34135**

All complaints will be investigated.
No personal issue will be raised for filing a complaint with Melanie Pugh DMD, PA.

I have read a copy of the Statement of Privacy Notice from the office of Melanie Pugh DMD, PA.

| _____ | _____ | _____ |
|---|---|---|
| SIGNATURE | DATE | PRINTED NAME |

Melanie Pugh, DMD, PA
Gentle Family & Cosmetic Dentistry

___ **I DO NOT** give the office of Dr. Melanie Pugh my permission to discuss my account, treatment or any other protected health information with anyone other than myself.

___ **I DO** give the office of Dr. Melanie Pugh my permission to discuss my account, treatment, or any other protected health information with the following:

_____ _____

NAME RELATIONSHIP

_____ _____

NAME RELATIONSHIP

May we leave a message at home confirming or cancelling an appointment?

**YES NO**

May we leave a message at your place of employment to have you return our call?

**YES NO**

_____ _____

**Signature** **Date**