Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. If you have any questions or need any help completing this form, please ask us – we will be happy to help!

PATIENT INFORMATION (CONFIDENTIAL):

Date: _____

Name: _____ Prefer to be called: _____
(First, Middle, Last)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____

Birthdate: _____ Social Security Number: _____-_____-_____ ❑ Minor ❑ Single ❑ Married

Email appt. confirmation okay? ❑ Yes ❑ No Text messaging appt. confirmation okay? ❑ Yes ❑ No

If Student, Name of School/College: _____ ❑ Full-time ❑ Part-time

Whom may we thank for referring you to our office? _____

Person to contact in case of emergency: _____ Phone: _____

RESPONSIBLE PARTY:

Name of person financially responsible for this account: _____

Relationship to patient: ❑ Self ❑ Parent ❑ Other: _____

Driver License Number: _____ Birthdate: _____

Employer: _____ Employer Phone: (_____)_____

INSURANCE INFORMATION:

Name of insured: _____ Relationship to Patient: _____

Insured's Birthdate: _____ Insured's Social Security Number: _____-_____-_____

Plan Name (usually the Employer): _____ Group #: _____

Insurance Company: _____ Insurance Phone: (_____)_____

Ins. Address: _____City: _____ State: _____ Zip: _____

Our office will gladly create and file your insurance claims for your convenience. We do ***not*** verify specific plan coverage, but will ***estimate*** your benefits based on a "typical" dental insurance plan, or based on the information we have gathered about your specific dental plan. As a courtesy to our patients, we will accept assignment from your ***primary*** insurance company and wait for **30 days** for your insurance to pay your dental insurance claim. You will be expected to pay the difference between the full fee and the insurance ***estimate*** at the time services are rendered unless other financial arrangements are discussed in advance. You will remain responsible for your entire account balance regardless of any insurance coverage or any insurance estimate given to you. If a claim remains unpaid after 30 days, you will receive a statement for the balance due on your account within 10 days, along with copies of the unpaid claim(s) so you may follow up with the insurance company regarding the status of the unpaid claim(s).

⟹ **YOUR BALANCE BECOMES DUE BY YOU IF YOUR INSURANCE HAS NOT PAID WITHIN 30 DAYS.**

I understand and agree to the insurance acceptance guidelines outlined above. I authorize my insurance company to pay Dr. Hinton directly for claims that would otherwise be paid to the subscriber.

_____

Signature – Person Financially Responsible for Account Date

FINANCIAL COMMITMENT:

I understand that the fee for services rendered are due at the time of service unless specific financial arrangements are made in writing in advance. I understand that 18% APR interest will be charged for accounts past due.

FF	MA
L	NPM

_____

Signature – Person Financially Responsible for Account Date

OVER ⟶

MEDICAL HISTORY

Yes ☐ **No** ☐ Are you under a physician's care now? **If Yes, Why?** _____

Physician: _____ **Phone:** _____

Yes ☐ **No** ☐ Have you ever been hospitalized or had any serious illness or injury?

If Yes, Discuss: _____

Yes ☐ **No** ☐ Are you taking any medications, pills, drugs, herbs or vitamins?

If Yes, Please list: _____

_____

Yes ☐ **No** ☐ Are you allergic to any medications or substances?

If Yes: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metals ☐ Latex

☐ Other(s): _____

Yes ☐ **No** ☐ Do you use tobacco? **If Yes:** ☐ Cigarettes ____ /day ☐ Chew ☐ Dip ☐ Other: _____

Women only: ☐ Pregnant/May Be Pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Do you now have or have you ever had any of the following? (Note: If you answer "Yes" to any of the starred***** conditions, please check with us – premedication with antibiotics may be required.)

	Yes	No
Need Premedication?	☐	☐
Artificial Heart Valve *	☐	☐
Artificial Joint *	☐	☐
AIDS	☐	☐
Alzheimer's Disease	☐	☐
Anemia	☐	☐
Angina/Chest Pain	☐	☐
Arthritis or Rheumatism	☐	☐
Asthma	☐	☐
Blood Transfusion (recent)	☐	☐
Breathing Problem	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Cold Sores / Fever Blisters	☐	☐
Diabetes	☐	☐

	Yes	No
Drug Addiction/Alcoholism	☐	☐
Epilepsy or Seizures	☐	☐
Excessive Bleeding	☐	☐
Fainting or Dizziness	☐	☐
Heart Attack/Disease	☐	☐
Heart Murmur	☐	☐
Heart Pace Maker	☐	☐
Hemophilia	☐	☐
Hepatitis A (infectious)	☐	☐
Hepatitis B or C	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
HIV Positive	☐	☐
Hypoglycemia	☐	☐
Kidney Problems	☐	☐

	Yes	No
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Lung Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Nervousness	☐	☐
Osteoporosis/Bisphosphonates	☐	☐
Psychiatric Care	☐	☐
Radiation/Chemo Treatment	☐	☐
Sinus Trouble	☐	☐
Stomach/Intestinal Disease	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Tumors or Growths	☐	☐
Ulcers	☐	☐

Yes ☐ **No** ☐ **Any other medical condition not listed?** _____

DENTAL HISTORY

Yes ☐ **No** ☐ Do your gums bleed while brushing or flossing?
Yes ☐ **No** ☐ Have you ever had periodontal treatment?
Yes ☐ **No** ☐ Are your teeth sensitive to hot or cold or sweets?
Yes ☐ **No** ☐ Do you feel pain in any of your teeth?
Yes ☐ **No** ☐ Do you have any sores in or near your mouth?
Yes ☐ **No** ☐ Do you have frequent headaches?
Yes ☐ **No** ☐ Do you clench or grind your teeth?
Yes ☐ **No** ☐ Do you bite your lips or cheeks frequently?
Yes ☐ **No** ☐ Do you chew ice?
Yes ☐ **No** ☐ Have you ever had orthodontic treatment?

Have you ever experienced any of the following jaw problems?

Popping or Clicking Sound **Yes** ☐ **No** ☐

Pain (joint, ear, side of face) **Yes** ☐ **No** ☐

Difficulty opening or closing **Yes** ☐ **No** ☐

What would you change about your smile?

☐whiter ☐straighter ☐no metal showing ☐close spaces

☐other: _____

How long since your last dental cleaning? _____

How often do you brush? _____ floss? _____

What is your chief dental concern? _____

Is there anything we can do to make your visits with us more comfortable for you? _____

_____

⇨ **To the best of my knowledge, all the preceding answers are correct and complete. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.**

Patient Signature:	**Date:**	**Dr Reviewed:**	**Date:**

One of the best services we provide for our patients is the creation of a personalized plan for accomplishing their dental goals. By answering the following questions, you can help us understand you and the dental future you desire. This will enable us to make recommendations in line with what *you* want.

NAME: _____ TODAY'S DATE: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLIES TO YOU:

_____ I want to keep my natural teeth for my lifetime [Longevity]

_____ I want a dazzling! Stunning! Beautiful! Smile

_____ I would like to replace missing teeth

_____ I would like to be free from pain/sensitivity and reduce the chance of pain/sensitivity in the future

_____ I am looking for a second opinion

_____ I am concerned about the cost of dental treatment

_____ I'm nervous about dental treatment

_____ I have had poor experiences in dental offices and have a concern with trust

_____ I'm a busy person & anticipate a problem working treatment into my day

PLEASE CHECK WHAT BEST EXPRESSES HOW YOU FEEL ABOUT THE FOLLOWING QUESTIONS:

How important is dental health to you?

_____ High priority

_____ Average

_____ Not important to me

There are often dental options to consider – in general, what type of dental treatment options do you want us to recommend?

_____ Ideal treatment options

_____ Average treatment options

_____ The minimum required

At what point in time do you want us to recommend treatment to you?

_____ When 'something' isn't ideal

_____ When 'something' is beginning to worsen

_____ When it already hurts or is broken

What level of treatment explanation would you like?

_____ Tell me "everything"

_____ Just give me the "basics"

_____ Don't explain anything, just "tell me what I need"

David M. Hinton DDS, PA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

'You May Refuse to Sign This Acknowledgement'

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}

David M. Hinton DDS, PA 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 04/14/2003, 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, counter-intelligence, 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 $0.50 for each page, $20.00 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: David M. Hinton D.D.S.

Telephone: 407-363-0365 Fax: 407-363-7707

E-mail: hintondds@aol.com

Address: 7575 Dr. Phillips Boulevard Suite 160 Orlando. FL 32819