Designing Smiles
Cosmetic and Family Dentistry

♦ W E L C O M E ♦

Thank you for selecting us. Please fill out this form in ink. If you have any questions or need assistance, please ask. We'd be happy to help.

Patient Information (Confidential)

Date _____

Name _____ E-mail Address _____

SS# _____ Birth date _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Preferred contact: ❑Cell ❑ Home ❑Work

Check Appropriate Box: ❑Minor ❑Single ❑Married ❑Widowed ❑Divorced ❑Separated

If Student, Name of School/College _____ City _____ State _____ ❑Full Time ❑Part Time

Patient/Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Person to Contact in Case of Emergency _____ Phone _____

Whom May We Thank for Referring You? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ E-mail Address _____

City _____ State _____ Zip _____ Home Phone _____

Driver's License # _____State____ Birth date _____ Cell Phone _____

SS# _____ Bank _____ Is this Person Currently a Patient in Our Office? ❑Yes ❑No

Employer_____

Employer's Address _____ City _____ State_____ Zip _____ Work Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS# _____ Date Employed _____

Name of Employer _____ Employer's Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Secondary Insurance

Do You Have Additional Insurance? ❑ Yes ❑No

Name of Insured _____ Relationship to Patient _____

Birth date _____ SS# _____ Date Employed _____

Name of Employer _____ Employer's Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

DENTAL ♦ HISTORY

Previous Dentist & Location _____ Last Exam Date _____ Last Cleaning Date _____

Reason for Leaving? (optional) _____

Current Dental Needs or Concerns _____

Reason for Visit Today? _____

Check any of the following concerns or desires:

❑Existing Discomfort ❑Replace Old Silver Fillings ❑Gum Disease ❑Mouth Odor ❑Whitening

❑Prevent Decay ❑Smile Makeover ❑ Straighten ❑Emergency Treatment

❍Are you having any PAIN in your teeth?

Where? _____ For how long? _____ How severe? _____

❍Have you noticed any broken fillings, broken teeth, or cracks in your teeth?
Where? _____
❍Have you noticed bleeding gums when you brush or floss?

❍Do you have any teeth that are sensitive to hot, cold, sweets, or air?
Where? _____ For how long? _____ How severe? _____

❍Have you noticed any bumps, sores or lumps in or near your mouth? ❑Yes ❑No
❍Have you ever experienced any head, neck or jaw injuries? ❑Yes ❑No

❑Clicking/Popping ❑Difficulty chewing ❑Pain (joint, ear or side of face) ❑Frequent Headache

❑Clenching/Grinding ❑Jaw locking open/closed ❑Biting cheeks or lips

❑Difficulty opening/closing

Have you had Orthodontics, Braces, or Invisalign? ❑Yes ❑No Approximate Date of Completion _____

Orthodontist's Name _____ Location _____

Have you ever Whitened or Bleached your teeth? ❑ Yes ❑ No Products used _____

Please darken the level of fear you have about your dental visits:

low fear ⇦ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⇨ high fear

Have you ever had a bad experience at a dental office? What happened? _____

Would you like to know more about any of the following relaxing amenities?

❑Nitrous oxide/laughing gas ❑ Sedative medications ❑Music ❑TV/Video ❑Blankets/Pillows

What would you like to change about your smile?

❍Tooth Shape ❍Spacing ❍Color ❍Size ❍Straightness ❍Bite ❍Breath ❍Overall Smile

When discussing your treatment plan, do you prefer to receive?

❑ Big picture summary ❑What's next only? ❑Itemized, detailed explanation

I certify that I have read and understand the above information to the best of my knowledge and have answered the questions accurately. I authorize the dentist to release any information or records necessary to obtain payment from my insurance company, and authorize benefits to be paid directly to my dental office. I understand that I am financially responsible for any balances that I incur for services rendered.

Signature _____ Printed Name _____ Date _____

M E D I C A L ♦ H I S T O R Y

Physician's Name_____ Phone _____

Have You Been Hospitalized in the Last Five (5) Years ❑ yes ❑ no

Please Explain: _____

_____

Preferred Pharmacy _____ Phone _____

Pharmacy Location _____

DRUG ALLERGIES (Please check/circle all that apply)

❍ Antibiotics.....Amoxicillin Clindamycin Cephalexin Erythromycin Penicillin Sulfa.....other_____

❍ Pain Medications.....Aspirin Codeine Darvocet Hydrocodone Oxycodone NSAIDS Tylenol.....other_____

❍ Dental Local Anesthesia.....Benzocaine Epinephrine Lidocaine Septocaine Carbocaine Marcaine.....other_____

❍ Sedatives.....Halcion (Triazolam) Valium (Diazepam) Xanax (alprazolam) Ambien (Zolpidem)....other_____

❍ Metals.....Nickel Mercury Costume Jewelry Copper Gold Silver Amalgam.....other_____

❍ Latex /Rubber.....Latex gloves Rubber dam Elastic Band-aids Rubber cups (polishing).....other_____

Medical History

❍Artificial/Prosthetic Heart Valve
❍Cardiac Transplant
❍Immunosuppression
❍Congenital Heart Defect (CHD)
❍Heart Murmur w/ regurgitation
❍Orthopedic Surgery
❍Pins, posts, hip replacement
❍Previous Infective Endocarditis
❍Prosthetic Joints
❍Recent Heart Surgery last 6 mo
❍Rheumatic/Scarlet Fever
❍Shunts
❍Sickle Cell Anemia

Other disorder not listed:

_____

_____

❍Acid Reflux
❍AIDS
❍Allergies
❍Angina
❍Anemia
❍Arthritis
❍Asthma
❍Bleeding Tendency
❍Blood Disorder
❍Cancer
❍Chemotherapy
❍Chest Pain
❍COPD
❍Diabetes
❍Emphysema
❍Epilepsy

❍Fainting/Dizziness
❍Glaucoma
❍Hearing Impairment
❍Heart Attack
❍Heart Surgery
❍Heart Trouble
❍Hepatitis A-B-C
❍Herpes Oral
❍High Blood Pressure
❍Irregular Heartbeat
❍Kidney Disease
❍Liver Disease
❍Lung Disease
❍Organ Transplant
❍Osteoporosis
❍Pacemaker Heart

❍Paget's Disease
❍Periodontal Disease
❍Parathyroid Disease
❍Persistent Cough
❍Pregnancy/Nursing
❍Prostate Disease
❍Psychiatric Treatment
❍Radiation Treatment
❍Shortness of Breath
❍Sinus Trouble
❍Steroid or Cortisone Use
❍Stroke
❍Strong Gag Reflex
❍Thyroid Disease
❍Transient Ischemic Attack
❍Tuberculosis
❍Ulcers

Current prescription medications: _____

Current Herbal or Over the Counter Medications: _____

Have you ever taken medications for OSTEOPOROSIS? ❑Yes ❑No

If so, Which drug? ❑Actonel ❑Aredia ❑Boniva ❑Fosamax ❑Zometa ❑Other

Do you smoke, chew tobacco, or dip? _____ # of years?_____ How often?_____

Are you at risk for oral cancer? (Check all that apply)

❑Alcohol Use ❑White or Red Patches in Mouth ❑Sun Exposure ❑HPV virus ❑Tobacco

Do you ever use any recreational drugs? ❑ Yes ❑ No Be specific: _____

For your protection: Some drugs may interfere with dental anesthetics, prescriptions, or sedatives, and their combinations can be dangerous if combined. All information provided is strictly confidential and will not be shared.

I certify that I have answered the questions on this health history accurately and completely.

Signature _____ Printed Name _____ Date _____

Assignment of Benefits Form

Angela Hilton-Foley, DMD, PA

Date:_____

Patient Name: _____
Address _____
City _____State _____ Zip_____
Phone: _____

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

I, _____understand that services rendered to me by Angela Hilton-Foley and her associates, are my financial responsibility and that the Provider will bill my insurance company, as a courtesy. I authorize my insurance company to pay my benefits directly to Angela Hilton-Foley, DMD, PA and I understand that I will be fully responsible for any outstanding balance on my account.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. Rather than pay in full at this time, I have chosen to assign the benefits for the estimated portion remaining, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my Insurance Company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a claim. I also authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should my insurance company send payment to me, I will forward the payment to Angela Hilton-Foley, DMD, PA within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event Patient receives any check, draft, or other payment subject to this Agreement, I will immediately deliver said check, draft, or payment to Provider. Any violations of this agreement will, at Provider's election, terminate Patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Angela Hilton-Foley, DMD,PA to facilitate payment utilizing the credit card number on file to resolve the balance.

Dated: _____ Signature of Policyholder/Patient/Guardian: _____

Printed Name: _____

Witness: _____

Designing Smiles 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 CAREFULLY; THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

The purpose of this Notice of Privacy Practices is to inform you of our policies used to protect privacy of personal information.

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 privacy notice takes effect September 23, 2013, 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 and applicable by 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.

Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities.

You have the right to get a copy of your paper or electronic medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information in a timely manner, without delay for legal review. Usually within 30 days of your request. We may charge a reasonable cost-based fee for copying as authorized by the Florida Board of Dentistry but we will not condition copying upon payment of a fee for services rendered.

You have the right to ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing within 60 days.

You have the right to request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will agree to all reasonable requests.

You have the right to ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request and may say "No" if it will affect your care. If you pay for a service out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "Yes" unless a law requires us to share that information.

You have the right to get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior to the date you ask, who we shared it whit and why. We will include all the disclosures except those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make.) We'll provide one accounting a year for free, but will charge a reasonable cost-based fee if you request another within 12 months.

You have the right to get a copy of the privacy notice. You can ask for a paper copy of this notice at anytime, even if you have agreed to receive the notice electronically we will provide you with a paper copy promptly.

You have the right to choose someone to act for you. If you have given someone medical power of attorney or is someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

You have the right to file a complaint if you feel your rights are violated. You can file a complaint if you feel we have violated your rights by contacting us using the information at the bottom of this page. You can file a complaint with the U.S Department of Health and Human Services. We will not retaliate against you filing a complaint.

For certain health information you can tell us choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

You have both the right and choices to tell us to:

Share information with your family, close friends or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. *If you are unable to tell us your preferences, (ex: you are unconscious) we may go ahead and share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission and the written permission specifically lists the type of information being disclosed and prevents re-disclosure: Marketing purposes, sale of your information, most sharing of notes regarding psychotherapy, HIV, and/or substance abuse. In the case of fundraising: we may contact you for fundraising efforts, but you can tell us to not contact you again.

Our Uses and Disclosures: *How do we typically use or share your health information?*

We typically use or share your information to:

Treat you We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our Organization We can use and share your health information to run our practice, improve your care and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for services We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues We can share health information about you for certain situations, such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse; neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research We can use or share your information for health research.

Comply with the law We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests We can share health information about you with organ procurement organizations.

Work with medical examiner or funeral director We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation law enforcement and other government requests We can use or share health information about you for workers compensation claims, law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities : We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices in this notice and give you a copy of it.

We will not use or share your information other than as described here, unless you tell us we can in writing. You may change your mind at anytime. Let us know in writing.

Changes to the terms of this notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Other information We do not create or manage a hospital directory. We do not create or maintain psychotherapy and/or substance abuse information at this practice. We do not sell patient information in this practice. We do not engage in fundraising in this practice. We do not engage in research studies at this practice. We may ask you about HIV status because it is pertinent to your dental care but will make no further disclosure of such information without specific written consent from you or otherwise required by law. We will never share any psychotherapy, HIV, or substance abuse records without your written permission. A general authorization for release of records is NOT sufficient for us to release this type of information. We will ask you sign a separate written consent form that specifically mentions this type of information before we release this type of information. If you direct us to release this type of information, we will instruct the recipient that further disclosure by the recipient requires your written consent. Under Florida Law, we are unable to submit claims to payers (your health plan) under assignment of benefits without your signature on our consent form. We will not condition treatment on your signing a consent form, but unless you pay in full out-of-pocket, we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the consent or revoke it.

Questions and Complaints If you want more information about our privacy practices have a question or concern about your personal information; please contact us as indicated below.

Our Privacy Official: Dr. Angela Hilton-Foley
Telephone: (813) 891-1212
Address: 13017 W, Linebaugh Ave, Tampa, Florida 33626
Email: info@designingsmilestampa.com

Designing Smiles

Angela Hilton-Foley, DMD, PA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the dental office of **Designing Smiles, Angela Hilton-Foley, DMD, PA**

this ___ day of _____, 20_____. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Print your name

_____
Signature

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority

_____
_____.

Thank you. If you have any questions about this form or the attached notice, please contact our Privacy Official: **Angela Hilton-Foley, DMD.**

You may refuse to sign this acknowledgment

Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment ____
Unable to communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign ____

(describe)_____
_____
_____

_____
Signature of privacy official or associate

Credit Card on File:

In our efforts to **Go Green** and become a paperless office, we have implemented the following policy. You will be asked for a credit card number at the time you check in. The information will be held securely until your insurance has paid their portion, and notified us of your financial responsibility. At that time any remaining balance due to Designing Smiles will be charged to your credit card. We will notify you by phone, email or mail prior to charging your account. If you prefer not to keep a credit card on file, or you do not have a credit card, full payment is expected at the time of treatment. We can file your insurance and have the insurance company reimburse you instead.

You will benefit from this arrangement because you will no longer have to take the time to prepare mail and respond to billing statements, write out checks, pay for postage and envelopes, etc. It will be an advantage to us, since it will greatly decrease the number of paper statements that we have to generate and post in the mail. This policy is a win-win for everyone by keeping the costs of health care down and by allowing us to concentrate first and foremost on your dental needs.

To alleviate any concerns that you may have, our computers are password protected, fire walled, HIPPA compliant, and completely secure. Your information will never be shared, all paper copies will be scanned into the computer, and promptly shredded for complete and total security. All personal information, including credit card information is securely embedded in a complicated dental software program, used for that purpose. Our office is protected by an alarm system and only Dr. Hilton-Foley has the key to the office.

Our credit card on account policy in no way will compromise your ability to dispute a charge. We will email your statement, receipt, or a copy of your EOB (explanation of benefits). All co-pays and deductible amounts will be due at the time of your visit on the date of service, as usual.

Credit Card on File

Patient Name: _____ Family Member's Names: _____

Cardholder's Name: _____ [ ]Visa [ ]MasterC [ ]AmEx [ ]Discover [ ]CareCredit

Cardholder's Address: _____

Account #: _____ Expiration date: _____ Security Code: _____

By signing below, I authorize, Designing Smiles and its associates, to charge any remaining balances due on my account, or that of my family members listed above, and I agree to abide by the terms in this financial policy.

Signature (Responsible Party) _____ **Date:** _____

Print Name: _____

Billing Address (if different):_____

Designing Smiles *Angela Hilton-Foley, DMD*