PATIENT REGISTRATION _____ _____ *WEKIVA DENTAL*

Mark S. Offenback, D.D.S., P.A.
686 Hunt Club Blvd., Suite 100
Longwood, FL 32779

Welcome to our office! We are so glad you have chosen us to meet and exceed your dental expectations. Please take the time needed to complete our patient registration, including the insurance information.

DATE:_____

PERSONAL INFORMATION

Last_____First_____M.I._____Preferred_____

Male_____Female_____Married_____Partnered_____Single_____Other_____Child_____

BIRTHDATE_____SOCIAL SECURITY#_____

STREET _____APARTMENT #_____

CITY_____STATE_____ZIP_____

HOME PHONE _____WORK PHONE _____

CELL _____E-MAIL _____

RESPONSIBLE PARTY

NAME _____

RELATIONSHIP TO PATIENT_____

HOME PHONE_____WORK PHONE_____

CELL_____E-MAIL_____

ADDRESS_____

EMERGENCY CONTACT_____PHONE _____

EMPLOYER_____PHONE_____

OCCUPATION_____

INSURANCE INFORMATION (FOR VERIFICATION ONLY)

SUBSCRIBER_____SS#_____DOB_____

INSURANCE CO. _____GROUP#_____

PHONE_____

RELATIONSHIP TO SUBSCRIBER: Self_____Spouse_____ Child_____ Other_____

EMPLOYER FOR SUBSCRIBER_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

NAME: _____ DATE OF BIRTH: _____

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)_____

Previous Dentist _____ Last visit _____ Date of Last Cleaning _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ____Yes ____No If yes, please tell us why: _____

How often do you brush? _____ Do you floss? _____ Yes _____No How often? _____

Please circle each:

Y N I clench or grind my teeth during the day or while sleeping
Y N My gums bleed while brushing or flossing
Y N I like my smile
Y N I prefer tooth- colored fillings
Y N I avoid brushing part of my mouth because of pain
Y N I want my teeth whiter
Y N My gums feel tender or swollen
Y N I have problems eating
Y N I have had orthodontics
Y N I have had a facial or jaw injury
Y N I want my teeth straight

What are your dental priorities? _____

PATIENTS MEDICAL HISTORY

I consider my health to be (please check one) ____Excellent ____ Good ____ Fair ____Poor

Do you or have you had any of the following? (Please circle Y for yes or N for no)

Y N Heart Disease
Y N Heart Murmur/Mitral Valve Prolapse
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Abnormal Blood Pressure
Y N Anemia
Y N Prolonged Bleeding Disorder
Y N Tuberculosis or Lung Disease
Y N Asthma
Y N Hay Fever
Y N Sinus Trouble
Y N Epilepsy/Seizures
Y N Take an antibiotic before Dental Visit?
Y N History of Emotional or Nervous Disorder
Y N History of Drug Addiction
Y N Hepatitis Type _____
Y N Diabetes
Y N Excessive Urination and/or Thirst
Y N Infectious Mononucleosis (Mono)
Y N Herpes
Y N Immune Suppressed Disorder
Y N Sexually Transmitted/Venereal Disease
Y N Kidney Disease
Y N Tumor or Malignancy
Y N Cancer/Chemotherapy
Y N Radiation Treatment
Y N Have you ever taken Fen-Phen or Redux?
Y N AIDS
Y N Liver Disease
Y N Jaundice
Y N Hearing Loss
Y N Fainting Spells
Y N Glaucoma
Y N Herpes
Y N Ulcers
Y N Arthritis

women

Y N Taking Birth Control Meds
Y N Pregnant or Nursing

Y N Implants/Artificial Joints: _____

Y N Smoke or use tobacco. If yes, how much per day? _____ How many years? _____

Y N I have consumed alcohol within the last 24 hours?

Y N Had major surgery: (please write what type of surgeries and what years) _____

_____

Y N Do you have any other medical problem or medical history NOT listed on this form? _____

Are you allergic to: ____Aspirin ____Ibuprofen ____Sulfa drugs ____Penicillin ____Codeine ____Latex, Metals, Plastics

____Local Anesthetics (Novocaine) ____Other Medications _____

Please list all medications you are currently taking and for what condition_____

_____

_____

Physician's Name: _____ Phone: _____

_____ _____ _____ _____

Doctor's Signature **Date** **Patient Signature/or if a minor: Parent/Guardian** **Date**

HIPAA NOTICE OF PRIVACY PRACTICES
MARK S. OFFENBACK, D.D.S., P.A.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage you health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your Dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, Licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to dental school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law. Communicable Diseases: Health Oversight: Abuse or Neglect ; Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required y law. You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHT
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative4 location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any Objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

SIGNATURE BELOW IS ONLY ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES:

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

CONSENT FOR TREATMENT

I hereby authorize Dr. Mark Offenback and designated staff members to take radiographs, study models, photographs, and if needed, other diagnostic aids deemed necessary by the doctor to make a thorough diagnosis. Upon such diagnosis I authorize Wekiva Place Dental to perform all recommended treatment mutually agreed upon by me and to employ assistance as required to provide proper care.

I also understand that additional cavities or surfaces are sometimes detected as treatment progresses. In removing a defective filling or decay, a tooth may need a more complex restoration for adequate strength. In any healing art such as medicine or dentistry the response of living tissues to treatment cannot always be predicted.

You will receive a summary of diagnosed treatment. This will give you a good idea as to the condition of your dental health, and will list the approximate costs of having the needed treatment completed. In the final analysis the exact costs will be based on the treatment that was actually completed and the fees routinely charged for such procedures.

FINANCIAL POLICY

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of services unless other arrangements have been made previously. Please understand that a financial late charge may be automatically added monthly to a bill that is over 60 days old.

If you have insurance, keep in mind that your contract is between you and your insurance company and we are not a party to that contract. If insurance has not reimbursed our office within 60 days, we will look to you for payment. Be aware that some of the services we provide may be considered non-covered services by your insurance company.

Our fees reflect our excellent level of care. They are fair and reflect our high dental standards. Sometimes they are above the insurance companies “Usual and Customary” averages. Insurance companies come up with their own “average” of what they want to pay for a procedure. It has nothing to do with the actual cost of that procedure. Your insurance is your benefit meant to supplement your dental treatment needs.

I have read and agreed to the terms of the Consent for Treatment and Financial Policy.

_____

PRINT PATIENT NAME PRINT NAME OF RESPONSIBLE PARTY

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE
IF MINOR UNDER 18

DENTAL AUTHORIZATION

RELEASE OF PATIENT INFORMATION

To_____

_____

_____

I hereby authorize you to release and furnish to
Mark S. Offenback, DDS, PA,
686 Hunt Club Blvd, Suite 100, Longwood Fl 32779. (407)869-7333.
(person receiving the records) all dental records, x-rays, office records or other documents of any description and kinds from any dentist, hospital, or other healthcare provider, including billing information, regarding:

_____
Patient name(s)

Please e-mail digital x-rays to **frontdesk@wekivadental.com**

I understand these records may contain information not strictly dental in nature. Additionally, once these records are released, you have no responsibility for any further release of information and I release you from all responsibility or liability that may arise from this authorization.

Signed: _____
Patient or Patient's authorized representative

Witness:_____

Date: _____