Date _____

PATIENT INFORMATION

_____ Mr. _____ Mrs. _____ Ms. _____ Dr.

First Name _____ M.I. _____ Last Name _____

Sex: _____ Male _____ Female

Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Email _____

Soc. Sec. # _____ Driver's License # _____

Nearest Relative Not Living with You _____ Tel. (_____) _____

Dentist _____ Dentist Tel. (_____) _____

Medical Doctor _____ Referred By _____

Employer _____ Employer Tel. (_____) _____

Personal Payment Type: _____ Cash _____Check _____ Visa/MasterCard/Discover _____ CareCredit

How did you hear about our office? _____ *Newspaper advertisement* _____ *Website/Search Engine*_____ *Family or Friend* _____ *Other* _____ *Dentist*

Have you or a family member ever been to our practice? _____Yes _____ No If so, please list the patient's name _____

Who will be responsible for your account? _____ Self _____ Spouse _____ Father ____ Mother ____ Other _____

(If self, please skip to Next Section)

First Name _____ Last Name _____

Soc. Sec. # _____ Date of Birth _____ Age _____ Tel. (_____) _____

Address _____ City _____ State _____ Zip _____

Employer _____ Employer Tel. (_____) _____

Spouse or other guarantor information (if different than above)

First Name _____ Last Name _____

Soc. Sec. # _____ Date of Birth _____ Age _____ Tel. (_____) _____

Address _____ City _____ State _____ Zip _____

Employer _____ Employer Tel. (_____) _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY

Employer _____ Business Address _____

City _____ State _____ Zip _____ Employer Tel. (_____) _____

Plan _____ Ins. Co. Name _____

Address _____ City _____ State _____ Zip _____

Tel. (_____) _____ Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: _____ Male _____ Female Date of Birth _____ Tel. (_____) _____

Address _____ City _____ State _____ Zip _____

Soc. Sec. # _____ ID# _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____ Business Address _____

City _____ State _____ Zip _____ Employer Tel. (_____) _____

Plan _____ Ins. Co. Name _____

Address _____ City _____ State _____ Zip _____

Tel. (_____) _____ Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: _____ Male _____ Female Date of Birth _____ Tel. (_____) _____

Address _____ City _____ State _____ Zip _____

Soc. Sec. # _____ ID# _____

HEALTH HISTORY

To Our Patients: *Although Oral Surgeons primarily treat the area in and around your mouth, health problems that you may have and/or medications that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your responses are for our records only and will be considered confidential.*

Reason for Today's Office Visit: _____ Height _____ Weight _____

Are you in good health? ___ Yes ___ No If no, please describe: _____

Have there been any changes in your general health in the past year? ___ Yes ___ No If yes, please describe _____

Are you under the care of a physician? ___ Yes ___ No If yes, for what are you being treated? _____ Date of Last Visit _____

Have you had any illness, hospitalizations, or surgeries in the last 5 years? ___ Yes ___ No If yes, please describe _____

Do you have unhealed/recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth? ___ Yes ___ No If yes, please describe where _____

Do you have a prosthetic joint/implant? ___ Yes ___ No If yes, please describe where _____

Have you had a heart valve replacement or vascular graft? _____ Yes _____ No

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:	**Y**	**N**	***COMMENTS***	***HAVE YOU HAD OR DO YOU CURRENTLY HAVE:***	**Y**	**N**	***COMMENTS***
Rheumatic Fever?				Stroke?			
Damaged Heart Valves/Mitral Valve Prolapse?				Thyroid Trouble?			
Heart Murmur?				Diabetes?			
High Blood Pressure?				Low Blood Sugar?			
Low Blood Pressure?				Kidney Trouble?			
Chest Pain/Angina?				Are you on Dialysis?			
Heart Attack(s)?				Swollen Ankles, Arthritis, or Joint Disease?			
Irregular Heart Beat?				Osteoporosis / Osteopenia?			
Cardiac Pacemaker?				Osteonecrosis?			
Heart Surgery?				Stomach Ulcers?			
Bronchitis, Chronic Cough?				Contagious Diseases?			
Asthma?				Sexually Transmitted Diseases?			
Hay Fever/Sinus Problems?				Are you Immunosuppressed (possibly from transplant surgery, etc.)?			
Snoring/Sleep Apnea?				Problems with the Immune System (possibly from medication, surgery, etc.)?			
Difficult Breathing/Other Lung Trouble?				Delay in Healing?			
Tuberculosis?				A Tumor or Growth?			
Emphysema?				Radiation Therapy / Chemotherapy?			
Do You Smoke?				Chronic Fatigue / Night Sweats?			
Do You Use Chewing Tobacco?				A History of Drug Abuse?			
Blood Transfusion?				A History of Alcohol Abuse?			
Blood Disorder such as Anemia?				Are you on a Diet?			
Bruise Easily?				Contact Lenses?			
Bleeding tendency/abnormal bleed?				Eye Disease / Glaucoma?			
Hepatitis, jaundice, or liver disease?				Mental Health Problems?			
Infectious Mononucleosis?				A Removable Dental Appliance?			
Gallbladder Trouble?				Pain and Clicking of Jaws When Eating?			
Fainting Spells?				Malignant Hyperthermia?			
Convulsions/Epilepsy?				HIV/AIDS?			

MEDICATION – Are you now taking or have you taken:	**Y**	**N**	**LIST MEDICATION NAMES/COMMENTS**	***MEDICATION – Are you now taking or have you taken:***	**Y**	**N**	**LIST MEDICATION NAMES/COMMENTS**
Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, etc.)?				Any Tranquilizers, Sleeping pills, Anti-Depressants, and/or Narcotics on a Regular Basis?			
Any Bone Density Medications/Bisphosphonates (Aredia, Zometa, Fosomax, Actonel, etc.)?				Any Diet Pills?			
Any Natural Products, Herbal Supplement, or Homeopathic Remedy?				Any Other Kind of Medications, Drugs, or Pills?			

Please List Any Medications You Are Currently Taking: _____

ALLERGIES – Are you allergic to, or had a reaction to:	**Y**	**N**	***COMMENTS***	***ALLERGIES – Are you allergic to, or had a reaction to:***	**Y**	**N**	***COMMENTS***
Local Anesthetic (numbing med.)?				Codeine or other Narcotics?			
Penicillin?				Other Medications?			
Other Antibiotics?				Latex?			
Sulfa Drugs?				Soy?			
Sodium Pentothal, Valium, or other Tranquilizers?				Eggs/Yolk?			
Aspirin?				Sulfites?			

Please List Any Allergies or Past Reactions to other Drugs/Medications: _____

Please List Any General Allergies: _____

Is there a FAMILY HISTORY of:	**Y**	**N**	***Relation***	***Is there a FAMILY HISTORY of:***	**Y**	**N**	***Relation***
Cancer?				Heart Disease?			
Diabetes?				Anesthetic Problems?			

Is there any condition concerning your health that the Doctor should be told about? _____Yes _____No If yes, please describe? _____

Do you wish to speak to the doctor privately about anything? _____Yes _____No

IN CASE OF EMERGENCY, CONTACT:

Name _____ Home Tel. (_____) _____ Bus. Tel. (_____) _____

THIS SECTION (401-404) IS FOR WOMEN ONLY (men may skip to the next section)

Is there a possibility of pregnancy? _____Yes _____No If yes, when is the expected delivery date? _____

Are you nursing? _____Yes _____No

Are you taking birth control pills? _____Yes _____No

Women Note: Antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

I **certify** that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff responsibly for any errors or omissions that I have made in the completion of this form.

Signature of Patient X_____ **Date X**_____

(parent or guardian if patient is a minor)

AUTHORIZATION

I authorize my surgeon and his designated staff to perform an oral and maxillofacial evaluation for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Signature of Patient X_____ **Date X**_____

(parent or guardian if patient is a minor)

MOFFETT ORAL SURGERY
& DENTAL IMPLANT CENTER
Jeffrey V. Moffett, D.M.D., P.A.

Insurance Disclaimer

Please be advised that the treatment plan we provide is an estimate only. It is never guaranteed that the insurance company will pay what is estimated. The dental fees may vary depending on the final explanation of benefits from your dental insurance.

If the insurance company pays less than the amount estimated on the treatment plan or if the fees are higher than estimated, you are fully responsible for the balance.

If the insurance company pays more than the amount estimated you may be entitled to a refund. Please call the office if you believe you have a refund or credit on your account; patients generally receive their copy of the explanation of benefits before the provider receives payment. Refunds are issued biweekly.

If you have any questions regarding your explanation of benefits our friendly staff will be more than happy to help you the best we can. Many times, a simple telephone call will clear any misunderstandings.

Patient / Guardian Signature _____

Patient Name _____

Witness' Signature_____

Date _____

Financial Policy

For your convenience, we accept Visa, MasterCard, Discover, and personal checks. *We do not accept American Express and we do not accept personal checks over $500. If you are having treatment on the same day as the consultation, we do not accept personal checks over $250.* We also offer financing through Care Credit. We deliver the finest care at the most reasonable cost to our patients, therefore payment is due at the time service is rendered.

Please note that in concordance with the State of Florida NSF fee schedule, additional fees will apply for any returned checks/payments, as well as for any third party collection fees.

Please remember filing of insurance claims is a courtesy. You are fully responsible for all fees charged by this office regardless of your insurance coverage. Most insurance companies will respond within four to six weeks from the date of service. The treatment plan that you are provided is an *estimate* only. Any remaining balance after your insurance has paid is your responsibility. Your prompt remittance is appreciated.

If you have questions regarding your account, please contact us at 813-677-3331. Many times, a simple telephone call will clear any misunderstandings.

Patient / Guardian Signature _____

Patient Name _____

Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

Moffett Oral Surgery

Effective Date: March 26, 2013

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 is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 813-677-3331.

II. **We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each**:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.
To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.

• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization.

• Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes.

• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: Christine at 813-677-3331.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

Acknowledgement 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.

Print Name

Signature

Date