Big Boca Smiles/Big Tooth Boca
21301 Powerline Rd Suite 208, Boca Raton, FL 33433
(561) 482 8000
bigbocasmiles.com/



# NEW PATIENT FORM

## Basic Information

| | | | |
|---|---|---|---|
| Name: | | Gender: | |
| Preferred Name: | | DOB: | |
| SSN #: | | Marital status: | |
| Referral source: | | Employer: | |
| Referred by: | | Occupation: | |

## Contact Information

| | |
|---|---|
| Mobile phone: | |
| Home phone: | |
| Email: | |

## Address Information

| | |
|---|---|
| Street address: | |
| City: | |
| State: | |
| ZIP: | |

## Emergency Contact

| | |
|---|---|
| Full Name: | |
| Phone number: | |
| Relation: | |

## Work Information

| | |
|---|---|
| Street address: | |
| City: | |
| State: | |
| ZIP: | |

Patient's signature:

Date:

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# HEALTH HISTORY

| DOB:

## Summary

Medical Conditions

Allergies

Medications

## General Health Information

Are you currently under the care of a physician?

Physician phone number

Date of last physical exam

Are you presently being treated for any injury or illness?

Have you ever been hospitalized for an injury or illness?

Are you pregnant or planning to become pregnant?

Are you currently breastfeeding?

Are you required to pre-med with antibiotics before dental treatment?

Do you use alcohol?

Do you use or have you ever used tobacco?

Have you ever had an allergic reaction?

Preferred Pharmacy

Phone number

## Medical Conditions

**Please check all conditions that you have history of or are currently being treated for**

Do you have a history or are currently being treated for any Digestive conditions?

Do you have a history or are currently being treated for any Heart or Circulatory conditions?

Do you have a history or are currently being treated for any Neurological conditions?

Do you have a history or are currently being treated for any Lung or Breathing conditions?

Do you have a history or are currently being treated for any Autoimmune conditions?

Head or neck injuries?

Artificial Joint?

High cholesterol?

History of cancer?

Tumor or abnormal growth?

Radiation therapy?

| | |
|---|---|
| Chemotherapy? | |
| HIV / AIDS? | |
| Osteoporosis / osteopenia? | |
| Type I or Type II diabetes? | |
| Anemia? | |
| Kidney disease? | |
| Liver disease? | |
| Thyroid disease? | |
| Tuberculosis / measles / chicken pox? | |
| Any other medical condition we should know of? | |

## Medications

| **Please check all medications you are currently taking** | |
|---|---|
| Are you taking any pain medications? | |
| Are you taking any Antidepressants or Anxiety medications? | |
| Are you taking any Diabetes, Cholesterol, or Blood Pressure medications? | |
| Are you taking any Allergy or Asthma medications? | |
| Are you taking any Antibiotics? | |
| Are you currently taking any other medications or dietary supplements? | |

Patient's signature: Date:

Doctor's signature: Date:

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# DENTAL HISTORY

| DOB:

## Basic Information

| | |
|---|---|
| How would you rate the condition of your mouth? | |
| Previous Dentist | |
| How long have you been a patient? | |
| Date of most recent dental exam | |
| Date of most recent x-rays | |
| Date of most recent treatment (other than a cleaning) | |
| I routinely see my dentist every | |
| What is your immediate concern? | |

## Personal History

| Please answer Yes or No to the following | |
|---|---|
| 1. Are you fearful of dental treatment? | |
| 2. Have you had an unfavorable dental experience? | |
| 3. Have you ever had complications from past dental treatment? | |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? | |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? | |
| 6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma? | |

## Gum and Bone

| Please answer Yes or No to the following | |
|---|---|
| 7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? | |
| 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? | |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? | |
| 10. Is there anyone with a history of periodontal disease in your family? | |
| 11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? | |
| 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? | |
| 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? | |

## Tooth Structure

| Please answer Yes or No to the following |
|---|

| | |
|---|---|
| 14. Have you had any cavities within the past 3 years? | |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? | |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? | |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? | |
| 18. Do you have grooves or notches on your teeth near the gum line? | |
| 19. Have you ever broken teeth,chipped teeth, or had a toothache or cracked filling? | |
| 20. Do you frequently get food caught between any teeth? | |

### Bite and Jaw Joint

| **Please answer Yes or No to the following** | |
|---|---|
| 21. Do you have problems with your jaw joint? | |
| 22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? | |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? | |
| 24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed? | |
| 25. Are your teeth becoming more crooked, crowded or overlapped? | |
| 26. Are your teeth developing spaces or becoming more loose? | |
| 27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? | |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? | |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? | |
| 30. Do you clench or grind your teeth together in the daytime or make them sore? | |
| 31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? | |
| 32. Do you wear or have you ever worn a bite appliance? | |

### Smile & Face Characteristics

| **Please answer Yes or No to the following** | |
|---|---|
| 33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? | |
| 34. Have you ever whitened (bleached) your teeth? | |
| 35. Have you felt uncomfortable or self conscious about the appearance of your teeth? | |
| 36. Have you been disappointed with the appearance of previous dental work? | |

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# DENTAL INSURANCE INFORMATION

**I DOB:**

Created at: **03/20/2021 5:30:49 PM**

## Primary Insurance Information

| | |
|---|---|
| Do you have a dental insurance? | |
| Would you like to upload insurance card photo? | |
| Patient's relationship to the Insurance Holder | |
| Policy Holder's Name | |
| Policy Holder's Date of Birth | |
| Policy Holder's SSN | |
| Policy Holder's Address | |
| Policy Holder's City | |
| Policy Holder's State | |
| Policy Holder's ZIP | |
| Policy Holder's Phone Number | |
| Policy Holder's Employer | |
| Dental Insurance Company | |
| ID Number | |
| Group Number | |
| Phone number on the back of your insurance card | |
| Address on the back of your insurance card | |

## Secondary Insurance Information

| | |
|---|---|
| Do you have a secondary dental insurance? | |
| That's all! If you would like to add secondary insurance, you need to provide primary insurance first. | |
| Would you like to upload insurance card photo? | |
| Patient's relationship to the Insurance Holder | |
| Policy Holder's Name | |
| Policy Holder's Date of Birth | |
| Policy Holder's SSN | |
| Policy Holder's Address | |
| Policy Holder's City | |
| Policy Holder's State | |
| Policy Holder's ZIP | |
| Policy Holder's Phone Number | |
| Policy Holder's Employer | |
| Dental Insurance Company | |
| ID Number | |
| Group Number | |

| | |
|---|---|
| Phone number on the back of your insurance card | |
| Address on the back of your insurance card | |

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# FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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# PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 21301 Powerline Rd Suite 208, Boca Raton, FL 33433:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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# COMMUNICATION CONSENTS

## EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Big Boca Smiles/Big Tooth Boca offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Big Boca Smiles/Big Tooth Boca will use reasonable means to protect the security and confidentiality of email information sent and received. However, Big Boca Smiles/Big Tooth Boca cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Big Boca Smiles/Big Tooth Boca and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Big Boca Smiles/Big Tooth Boca.

Patient's signature: Date:

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## TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Big Boca Smiles/Big Tooth Boca, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Big Boca Smiles/Big Tooth Boca will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Big Boca Smiles/Big Tooth Boca cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Big Boca Smiles/Big Tooth Boca and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Big Boca Smiles/Big Tooth Boca.

Patient's signature: Date:

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# HIPAA – RELEASE OF INFORMATION AUTHORIZATION FORM

**I DOB:**

## HIPAA - RELEASE OF INFORMATION AUTHORIZATION FORM

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

| | |
|---|---|
| I want to provide the authorization | |

Information Regarding Person Authorizing Releasing His/Her Information

| | |
|---|---|
| Name of person authorizing release | |
| Date of Birth person authorizing release | |
| Personal Information to be released | |
| The above information may be released and/or received by | |

The following is an authorization allowing Big Boca Smiles/Big Tooth Boca to release information to whomever you designate. Big Boca Smiles/Big Tooth Boca is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

| | |
|---|---|
| Name of person/organization that the office may release my information to | |
| Relation of person/organization that the office may release information to | |
| Phone number of person/organization that the office may release information to | |
| I want to add a second person/organization | |
| Name of person/organization that the office may release my information to | |
| Relation of person/organization that the office may release information to | |
| Phone number of person/organization that the office may release information to | |
| I want to add a third person/organization | |
| Name of person/organization that the office may release my information to | |
| Relation of person/organization that the office may release information to | |
| Phone number of person/organization that the office may release information to | |
| I want this consent to | |

## AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Patient's signature: Date: