Stuart Periodontics 901 SE Ocean Blvd. Stuart, FL 34994 (P) 772-283-1400 (F) 772-283-1488

New Patient Health History

Date: _____ Name: _____ SSN: _____

Date of Birth: _____ If a child, parent's name: _____

Marital Status: Single_____ Married_____ Spouse's name: _____ Divorced_____ Widowed_____

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

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____ Ph: _____

General Dentist: _____ Physician: _____

Date of last Physical Exam: _____ Email Address: _____

Purpose of today's visit: _____ **ASA I II III IV**

Health History: It is vital that we are aware of any existing medical conditions that you may have. Periodontal and body health are closely related. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PLEASE CIRCLE THE FOLLOWING CONDITIONS THAT APPLY TO YOU.

Abnormal heart condition	Heart Murmur	High Blood Pressure	Rheumatic Fever	Pacemaker
Coronary Bypass Surgery	Angioplasty	Joint Replacement	Stroke	Glaucoma
Artificial Heart Valves	Artificial Knee	Artificial Hip	Osteoporosis	Epilepsy
Metal plates/screws	Radiation Therapy	Chemotherapy	Diabetes	HIV
Fainting or dizzy spells	Thyroid condition	Kidney disorder	Liver Disorder	Lung disorder
Tuberculosis	Stomach Disorder	Cold sores/Herpes	Hepatitis	Asthma
Drug/alcohol addiction	Psychiatric treatment	Pregnant	Blood Disorder	Bad Breath
Previous Perio treatment	Recent tooth loss	Spaces between teeth	Mouth/Jaw Injury	Loose Teeth
Use of Tobacco Products	Bleeding Gums	Sensitive Teeth	Other: _____	

ABNORMAL REACTION OR ALLERGY TO: PLEASE CIRCLE

Penicillin Sulfa Novacaine Codeine Aspirin Foods Pollen Any other drug— Please List:

_____

Any Known complications after dental treatment:

_____

Do you take Aspirin or aspirin containing products on a daily basis? _____

Please list **ALL** current medications including vitamins, supplements & Bisphosphonates: Fosamax, Actonel, Boniva, Didronel, Skelid, or IV Aredia/Zometa or Prolia or any SSRI medications such as Prozac, Cymbalta, Lexapro, Celexa, Paxil, or Zoloft.

_____

_____

_____

Have you been hospitalized in the past? Please Explain. _____

Any healing complications following surgery? Please Explain. _____

Is your general health good? _____

Do you require antibiotics before dental treatment? _____

COMMENTS: Describe any current Medical problems or treatment including drugs, pending surgery or any other information of medical importance not discussed.

_____

_____

_____

SIGNATURE _____ **DATE:** _____

Financial Policy

This statement is to inform you of our financial policy. Financial arrangements are both necessary and beneficial to maintaining a sound professional relationship. We wish to inform you of our office policy in this regard. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining your optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs**. All charges you incur are your responsibility regardless of your insurance coverage**. We must emphasize that as your periodontist, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a part of that contract. What is called dental insurance is more appropriately called a payment assistance program. It is an economic negotiation between an employer and an insurance company and usually does not cover all charges. Our fees are based on the treatment necessary and are not related to any payment assistance reimbursement schedule. **You are responsible for payment in full at time of service**. We are committed to help you to receive your maximum payment assistance. **Insurance predeterminations are not a guarantee that the insurance company will pay the determined amount, it is only an estimate and they may still decline services.** You should keep any predeterminations received just in case your insurer changes their mind and denies the claim. This will allow you to contact the insurance company to try to dispute their decision. As a courtesy to you we will help you process your insurance claims. In order for our office to file your insurance claim, you must bring your identification (license) and proof of insurance at each appointment. **Payment is due at the time service is provided**. Our office accepts cash, personal checks, Care Credit (minimum requirement) MasterCard, Visa, American Express and Discover. We offer payment plans through third party financing. If you would like more information regarding this, please check with our financial coordinator. **Returned checks will have a NSF fee of $35.00** and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience here at C. Nicholas DeTure, PA. By signing below you are acknowledging receipt of the financial policy. A copy will be provided to you upon request.

_____ _____

Signature **Printed Name**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am acknowledging receipt of the Notice of Privacy Practices and giving my consent for your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date**: _____

If this consent is signed by a personal representative on behalf of the patient: **Name:** _____

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize C. Nicholas DeTure, P.A., to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or C. Nicholas DeTure, P.A.'s health care operations. The patient information that may be emailed may include my x-rays, health history, and diagnosis, treatment, and payment records.

I understand that:

- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, C. Nicholas DeTure, P.A. may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- C. Nicholas DeTure, P.A. does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that C. Nicholas DeTure, P.A. already sent before receiving my written instructions to stop. This consent will be valid until I notify you in writing.

Patient name (please print) _____

Signature: _____ Date: _____

STUART CENTER
FOR LASER PERIODONTICS & IMPLANTS
Committed to your success

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