NEW IMAGE DENTISTRY
GENERAL and COSMETIC CARE

4923 Clark Road
Sarasota, FL 34233
(941) 922-9332

New Patient Information

Welcome to New Image Dentistry. We will do our best to make your apppoinments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, or fees, please feel free to ask. This confidential acquaintance form is important for our files and for your health. ***When you have completed the information, please click the "Print" button at the bottom of the page, then bring with you to your next appointment, or fax to our office:*** **(941) 922-8769.**
Thank you.

Patient Information

Date:

Patient Name	**Mailing Address** Address _____ City _____ State _____ Zip Code _____
Social Security Number	
Place of Employment	
Business Phone	**Email Address**
Marital Status	**Daytime Phone Number** (Area code and number)
If Minor, name of Parent or Guardian and phone number:	**Fax Number** (Area code and number)

Sex ◯ M ◯ F	**Age**	**Date of Birth - Mo/Date/Year**	**Driver's License Number**

Do you have dental insurance? ◯ Yes ◯ No

Person Responsible for your Dental Care:	**Your payment will be made by:**	**Dental Insurance Policy Holder**
Name _____ Address _____ City _____ State _____ Zip _____ Relationship _____ Telephone _____	◯ Cash ◯ Check ◯ Credit Card	**Policy Holder Social Security #** **Policy Holder Date of Birth - Mo/Date/Year** **Policy Holder Employer**

Name of Your Physician _____

Why did you leave your last dentist? _____

Whom may we thank for referring you to us? _____

Have you been a patient in our office before? ◯ Yes ◯ No

Date of your last dental visit _____

Reason for your last visit? _____

Do you have your Xrays or Dental Records? ◯ Yes ◯ No

Nearest Relative not Living with you _____

Have you EVER had any of the following (Check YES o r NO)

Heart Trouble	◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No
Chest Pain	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Anemia	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No	Drug Allergy	◯ Yes	◯ No	Epilepsy	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No	Seizures	◯ Yes	◯ No	Major Surgery	◯ Yes	◯ No
Hypertension/Hi BP	◯ Yes	◯ No	Blood Disease	◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No	Kidney Disease	◯ Yes	◯ No	AIDS Virus	◯ Yes	◯ No
____ Implant	◯ Yes	◯ No	Shortgness of Breath	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Thyroid Condition	◯ Yes	◯ No
						Parkinsons Disease	◯ Yes	◯ No

If you were to change one thing about your smile, what would you do?

Are you currently in any dental pain? ◯ YES ◯ NO Any part of your mouth sensitive to temperature or chewing? ◯ YES ◯ NO

Does food catch between your teeth? ◯ YES ◯ NO

Are you aware of your jaw clicking or popping when you chew or yawn? If yes, explain ◯ YES ◯ NO

Do you have frequent headaches? If yes, explain ◯ YES ◯ No

Are you allergic to any of the following? ◯ Penicillin ◯ Codeine ◯ Aspirin ◯ Local Injected Anesthetics ◯ Other Medications

Are you under the care of a physician for any reason? If yes, explain ◯ YES ◯ No

Are you currently or have you recently been taking drugs or medications? If yes, explain ◯ YES ◯ NO

Have you ever received Radiation Therapy (i.e. for tumors) of the face, head, neck or jaws? If yes, explain ◯ YES ◯ NO

Do you have a problem with bleeding or clotting? If yes, explain ◯ YES ◯ NO

Are there any other medical conditions of which we should be aware? If yes, explain ◯ YES ◯ NO

When was your last physical exam? Mo/Date/Year Was anything unusual or abnormal found? ◯ YES ◯ NO

If yes, explain

Female Patients: Are you taking birth control pills? ◯ YES ◯ NO Are you or could you be pregnant? ◯ YES ◯ NO

If yes, Name and Phone Number of OB/GYN

Please be reminded that payment is due on the date on which services rendered. Other arrangements must be made in advance.

Do your gums bleed when you brush your teeth or toothpick between them?	☐ Yes ☐ No
Are your gums red, swollen, or tender?	☐ Yes ☐ No
Are your gums pulling away from your teeth?	☐ Yes ☐ No
Do you see pus between your teeth and your gums when your gums are pressed?	☐ Yes ☐ No
Are your permanent teeth loose or separating?	☐ Yes ☐ No
Is there any change in the way your teeth fit together when you bite?	☐ Yes ☐ No
Is there any change in the fit of your partial dentures?	☐ Yes ☐ No
Do you have bad breath?	☐ Yes ☐ No
Do you participate in contact sports that could potentially damage your teeth or oral tissues?	☐ Yes ☐ No
Do you wake up with headaches, dry mouth, or choking sensations?	☐ Yes ☐ No
Are you restless or perspire in your sleep?	☐ Yes ☐ No
Do you suffer fatigue or depression?	☐ Yes ☐ No
Do you experience difficulty concentrating or staying awake during the day?	☐ Yes ☐ No
Have you experienced frequent heartburn or rapid weight gain?	☐ Yes ☐ No
Does snoring disrupt your sleep or your significant other's sleep?	☐ Yes ☐ No

Please rate the following situations based on this sleepiness scale: 0 = would never doze; 1 = slight change of dozing; 2 = moderate change of dozing; 3 = high chance of dozing:

Sitting and reading	◯0 ◯1 ◯2 ◯3
Watching television	◯0 ◯1 ◯2 ◯3
Sitting, inactive in a public place (e.g. theater, meeting)	◯0 ◯1 ◯2 ◯3
As a passenger in a car for an hour without a break	◯0 ◯1 ◯2 ◯3
Lying down to rest in the afternoon when circumstance permits	◯0 ◯1 ◯2 ◯3
Sitting and talking to someone	◯0 ◯1 ◯2 ◯3
In a car while stopped for a few minutes in traffic	◯0 ◯1 ◯2 ◯3

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We 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 Notice takes effect 5/14/03, 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 by applicable law. We reserve the right to make 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 significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practicesm or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health informaton to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health informaton to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health informaton in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practioner and provider performance, conducting training programs, accreditation, certification, licensing or crendentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not effect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health informationto a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose your health informaton to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose helath information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our ecperience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing purposes without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avery a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or discloseyour health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (TOy must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies we will charge you $1.00 per page, $___ per hour for the staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based for providing your health information in that format. If you prefer, we will prepare a summary or explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You may have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14th, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic email (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complainto us you may use the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Our Office:
Telephone: **(941) 922-9332**
Fax: (941) 922-8769
Email: **info@newimagedentistry.com**
Address: 4923 Clark Road, Sarasota, FL 34233

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 health information to carry out treatment, payment, and healthcare operations.

Notice of Privacy: You have the right to read our Notice of Privacy Practices before you decide whether to sign this 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 charges may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice:
Contact Our Office:
Telephone: **(941) 922-9332**
Fax: (941) 922-8769
Email: **info@newimagedentistry.com**
Address: 4923 Clark Road, Sarasota, FL 34233

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 continue treating you if you revoke this Consent.

PROFESSIONAL FEES:

1. I understand that substantial time is reserved for each treatment session and that additional charges may be applied for tardiness, broken appointments, and cancelled appointments without at least 24 hours notice.

2. I understand that occasionally a tooth which has received dental treatment will require further treatment and if necessary, an additional fee may be charged.

3. I understand that professional fees are levied at the time services are initiated and are due in full before or upon completion of treatment. I further understand that a finance charge equal to 18% (APR) will be applied on account balances beginning thirty days from the date treatment is completed.

4. I understand that the professional services are rendered and charged to me, not the insurance company. I understand services cannot be rendered to me on the assumption that professional fees will be paid by an insurance company. A pre-determination of benefits must precede treatment and an assignment of benefits made to the doctor if insurance benefits are to be used for payment of professional services.

5. I understand that if my account should be turned over for legal collection, I agree to pay for all cost of collection including postage, court costs, and attorney fees.

Signature _____ Date _____

I've had full opportunity to read and consider the contents of this History, Consent and Notice of Privacy Practices. I understand that by signing this document, I am giving consent to New Image Dentistry for the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I agree that by signing my name in the signature line constitutes my legal signature and agreement to the terms set forth above.
I understand that I need to bring in this signed, pre-filled form on my next visit to New Image Dentistry.

OFFICE USE ONLY

Reviewed by: _____ Date: _____

NEW IMAGE DENTISTRY
General Cosmetic and Implant Care
4923 Clark Rd., Sarasota, FL 34233
Phone: (941)922-9332, Fax: (941) 922-8769
E-mail: frontdesk1@newimagedentistry.com

Patient Authorization for Release of Dental Records To New Image Dentistry

Please provide New Image Dentistry with copies of all dental records, perio charting and x-rays pertaining to my dental treatment. I understand my actual dental record, by law, belongs to my dentist and the information contained in the record belongs to me. I agree to accept copies of such records and to pay any fee(s) for duplication as required.

_____

Patient Signature Today's Date

_____

Print Patient Name **Birth Date**

_____

Date of Last X-Rays - FMX or BW's

_____

Date of Last Perio Charting Date of Last Exam

_____

Dr.'s Name

_____

Dr.'s Phone # Dr.'s Fax #

_____

Dr.'s Address

_____

_____

Dr.'s Email Address

Please provide a copy of Perio Charting and any X-rays, FMX
Fax to 941-922-8769 or Email to frontdesk1@newimagedentistry.com

Clear Form Print Form