welcome

PATIENT NUMBER

Age _____ Date _____

Patient's Name _____ Date of Birth _____ ❑ Male ❑ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street _____

City _____ State ____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

_____

DATE _____

Form No. T110R

REGISTRATION

welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ..... YES NO
   How often: _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacement? ..... YES NO
    If yes, explain _____
13. Would you like to know about permanent replacements? ..... YES NO
14. Have you ever had any problems or complications with previous dental treatment? .... YES NO
    If yes, explain: _____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw click or pop? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? ..... YES NO
19. Does food get caught in your teeth? ..... YES NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? ..... YES NO
    When? _____
22. Do you experience dry mouth? ..... YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ..... YES NO
    How often? _____
25. Are any of your teeth loose, tipped, shifted or chipped? ..... YES NO
26. Are you unhappy with the appearance of your teeth? ..... YES NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is offensive at times? ..... YES NO
29. Have you ever had gum treatment or surgery? ..... YES NO
    What? _____
    Where? _____
    When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

Form No. T150DH

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ( ) Yes ( ) No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No If yes, please explain: _____
Have you ever had a serious head or neck injury? ( ) Yes ( ) No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ( ) Yes ( ) No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ( ) Yes ( ) No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ( ) Yes ( ) No _____
Are you on a special diet? ( ) Yes ( ) No
Do you use tobacco? ( ) Yes ( ) No
Do you use controlled substances? ( ) Yes ( ) No

Women: Are you
Pregnant/Trying to get pregnant? ( ) Yes ( ) No Taking oral contraceptives? ( ) Yes ( ) No Nursing? ( ) Yes ( ) No

Are you allergic to any of the following?
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Local Anesthetics [ ] Acrylic [ ] Metal [ ] Latex [ ] Sulfa drugs
[ ] Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ( ) Yes ( ) No	Cortisone Medicine ( ) Yes ( ) No	Hemophilia ( ) Yes ( ) No	Radiation Treatments ( ) Yes ( ) No
Alzheimer's Disease ( ) Yes ( ) No	Diabetes ( ) Yes ( ) No	Hepatitis A ( ) Yes ( ) No	Recent Weight Loss ( ) Yes ( ) No
Anaphylaxis ( ) Yes ( ) No	Drug Addiction ( ) Yes ( ) No	Hepatitis B or C ( ) Yes ( ) No	Renal Dialysis ( ) Yes ( ) No
Anemia ( ) Yes ( ) No	Easily Winded ( ) Yes ( ) No	Herpes ( ) Yes ( ) No	Rheumatic Fever ( ) Yes ( ) No
Angina ( ) Yes ( ) No	Emphysema ( ) Yes ( ) No	High Blood Pressure ( ) Yes ( ) No	Rheumatism ( ) Yes ( ) No
Arthritis/Gout ( ) Yes ( ) No	Epilepsy or Seizures ( ) Yes ( ) No	High Cholesterol ( ) Yes ( ) No	Scarlet Fever ( ) Yes ( ) No
Artificial Heart Valve ( ) Yes ( ) No	Excessive Bleeding ( ) Yes ( ) No	Hives or Rash ( ) Yes ( ) No	Shingles ( ) Yes ( ) No
Artificial Joint ( ) Yes ( ) No	Excessive Thirst ( ) Yes ( ) No	Hypoglycemia ( ) Yes ( ) No	Sickle Cell Disease ( ) Yes ( ) No
Asthma ( ) Yes ( ) No	Fainting Spells/Dizziness ( ) Yes ( ) No	Irregular Heartbeat ( ) Yes ( ) No	Sinus Trouble ( ) Yes ( ) No
Blood Disease ( ) Yes ( ) No	Frequent Cough ( ) Yes ( ) No	Kidney Problems ( ) Yes ( ) No	Spina Bifida ( ) Yes ( ) No
Blood Transfusion ( ) Yes ( ) No	Frequent Diarrhea ( ) Yes ( ) No	Leukemia ( ) Yes ( ) No	Stomach/Intestinal Disease ( ) Yes ( ) No
Breathing Problem ( ) Yes ( ) No	Frequent Headaches ( ) Yes ( ) No	Liver Disease ( ) Yes ( ) No	Stroke ( ) Yes ( ) No
Bruise Easily ( ) Yes ( ) No	Genital Herpes ( ) Yes ( ) No	Low Blood Pressure ( ) Yes ( ) No	Swelling of Limbs ( ) Yes ( ) No
Cancer ( ) Yes ( ) No	Glaucoma ( ) Yes ( ) No	Lung Disease ( ) Yes ( ) No	Thyroid Disease ( ) Yes ( ) No
Chemotherapy ( ) Yes ( ) No	Hay Fever ( ) Yes ( ) No	Mitral Valve Prolapse ( ) Yes ( ) No	Tonsillitis ( ) Yes ( ) No
Chest Pains ( ) Yes ( ) No	Heart Attack/Failure ( ) Yes ( ) No	Osteoporosis ( ) Yes ( ) No	Tuberculosis ( ) Yes ( ) No
Cold Sores/Fever Blisters ( ) Yes ( ) No	Heart Murmur ( ) Yes ( ) No	Pain in Jaw Joints ( ) Yes ( ) No	Tumors or Growths ( ) Yes ( ) No
Congenital Heart Disorder ( ) Yes ( ) No	Heart Pacemaker ( ) Yes ( ) No	Parathyroid Disease ( ) Yes ( ) No	Ulcers ( ) Yes ( ) No
Convulsions ( ) Yes ( ) No	Heart Trouble/Disease ( ) Yes ( ) No	Psychiatric Care ( ) Yes ( ) No	Venereal Disease ( ) Yes ( ) No
			Yellow Jaundice ( ) Yes ( ) No

Have you ever had any serious illness not listed above? ( ) Yes ( ) No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Today's Dentistry
Financial/Insurance Policy

As a courtesy to our patients, we complete all insurance forms relative to dental service rendered. We do our very best to give an accurate estimation of how much dental insurance will cover for a given procedure. However, insurance estimation is not a guarantee of payment. Actual benefits will be determined when services are completed and submitted for payment. Please keep in mind you are responsible for your total obligation should your insurance result in less coverage than anticipated.

Patients with out-of-network insurance will be asked to pay in full for services rendered. However, we will be happy to fill out the claim on your behalf indicating direct payment to the patient.

Please remember that your policy is with your employer and your insurance company. Our office has no control over your benefits. We will however make every effort to get the maximum coverage for your individual policy allows for service.

Your signature indicates that you:

- Have read and understand the above information
- Out-of-network insurance patient will file claim provided for their reimbursement
- Understand that payment is expected at time service is rendered, regardless of whether the responsible party is present at time of appointment.

Patient Name:_____ Date:_____

Patient Name printed:_____

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Extractions
Caps/Crowns
Bridges
Root Canal
Braces
Gum Treatment
Cosmetic
Implants
www.TodaysDentistryVenice.com
Ty Griffiths D.M.D.
1872 South Tamiami Trail Suite F ·Venice Florida 34293

Dear Valued Patient

CANCELLATION POLICY:

We pride ourselves on keeping our costs affordable for our patients. One way we do that is efficient use of equipment and professional staff. If your appointment time becomes inconvenient for you, we are always happy to change it if you provide us with two business days' notice. This allows us to schedule in a patient who may be in urgent need of care.

Missed or broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. This interferes with your dental treatment and creates unnecessary scheduling problems for other patients.

We strive to accommodate the scheduling needs of our patients, and we will make every effort to keep your schedule on time. Failure to provide us with 48 hours advance notice or failure to show up for a scheduled appointment will result in a appointment deposit fee or "walkin only" status.

Our goal in communicating our cancellation/no show policy is to avoid any extra charges from occurring.

We thank you for your cooperation and understanding

Signature:_____ Date:_____

[Insert Name of Practice]

NOTICE OF PRIVACY PRACTICES

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, 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 applicable law permits the changes. We reserve the right to make the 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 a 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 practices, 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 health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

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. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may 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 to the privacy 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.

Provider Contact Office: _____

Telephone: _____ Fax: _____

E-Mail: _____

Address: _____

_____
[Insert Name of Practice]

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Handle Me With Care

- ☐ I gag easily.
- ☐ I feel out of control when I am lying down in the dental chair.
- ☐ I have not been to the dentist for a long time and I feel uncomfortable about what will say or think about my teeth and my dental hygiene.
- ☐ I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.
- ☐ Pain relief is a top priority to me.
- ☐ I don't like shots, or I've had a bad reaction to shots.
- ☐ Please tell me what I need to know about my mouth so I can make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ I don't like the dental office smells.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front. No money surprises, please.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I don't like being left alone in the treatment area.
- ☐ I have problems with my back.
- ☐ I don't like the chair tipped back too far.
- ☐ I do not like to see dental instruments.
- ☐ I need to talk to you first, without sitting in the dental chair.
- ☐ Other concerns I would like to talk about (Please specify):

_____

_____

_____

_____

_____

_____

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Caps/Crowns
Bridges
Root Canal
Braces
Gum Treatment
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www.TodaysDentistryVenice.com
Ty Griffiths D.M.D.
1872 South Tamiami Trail Suite F • Venice Florida 34293

I, _____give Dr. Griffiths/Staff permission

to give the following information to_____:

__Treatment

__Financial

__All information

__Other, (specify)_____

Signed_____ Date_____

This document will remain in affect until patient requests otherwise in writing.

Please ONLY sign if granting above permission.