What to Expect During Your First Visit to Northwood Dental of Clearwater, FL

Greetings New Patient!

Welcome! Here at Northwood Dental, our practice is committed to providing you and your family with trustworthy, friendly, gentle, and affordable dental care. We understand that you or your family may feel anxious about visiting a new dentist. We are very sensitive to our patient's needs, and it is our goal to make you feel comfortable and well cared for.

The first visit will be for a comprehensive new patient exam. Typically, we will schedule you for a second visit to have your teeth professionally cleaned however this is flexible case by case so don't be afraid to ask.

During your first visit, we will review your dental and medical history forms, and take digital X-rays. One of our doctors will take time to get to know you and talk with you about your oral health concerns. Together, you and he/she will look at your X-rays and "take a tour of your mouth." As he/she examines your teeth, gum tissue and other soft tissue, they will show you any areas of health and functional concerns. During this collaborative exam, it is an ideal time to discuss aesthetic issues that have bothered you. The doctor will answer questions you may have.

When you schedule your first appointment with us, tell us about your primary concerns so you are scheduled appropriately, and there is time in the schedule to address any urgent problem.

We will schedule new patients for their first hygiene appointment on a later day unless pre-scheduled. One of our dental hygienists will clean and polish your teeth, as well as make a detailed record of the health of the gum tissue around each tooth. Northwood Dental takes a friendly and caring approach to solving complex oral health issues.

If you have multiple dental problems to be solved, a comprehensive treatment plan is designed for you. In this case, the doctor will then sit down with you to review what he/she thinks is the best course of treatment. Before this subsequent appointment, he/she will study your oral health record, models, and photos; and will spend focused time on a treatment plan that addresses the causes of the problems and will predictably provide lasting results.

Northwood Dental
3023 Eastland Blvd, Building H, Suite 112 Clearwater, FL 33761
www.northwood-dental.com
Tel. 727.796.5161

When you meet, your doctor will provide you with details about your treatment options in a language that you can understand and explain the different phases of treatment. Before accepting treatment, you will be fully informed about how the proposed treatment plan will meet your oral health goals, the importance of taking the proposed steps, the estimated fees, and your payment options.

We really do care about your long-term satisfaction. Besides, the joy our patients express after achieving restored health and appearance means the world to us!

Check out our Online Google Reviews to see why so many patients love Northwood Dental!

Our doctors and entire team are honest, compassionate, and caring. We believe our patients deserve the best of individualized care. This fully-informed approach to treatment planning and our focus on your long-term satisfaction may be unlike any dentistry you have ever experienced before.

Please remember to bring with you on your first visit:

- Download and complete our New Patient Registration Forms.
- If you have insurance, bring your insurance card to the appointment. Our financial coordinator will be happy to review your dental benefits with you.

"Our wellness team is dedicated to promoting and maintaining your dental health, ultimately eliminating the need for future treatment.
*A great smile starts with **YOU** and a healthy smile continues with **US**!*

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DENTAL REGISTRATION

PATIENT INFORMATION

Date: _____

Patient Name (last) _____

(first) _____ (middle initial) _____

Name you prefer to be called: _____

Address: _____

City: _____

State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____

Birthdate: _____

SSN: _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

Occupation: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Spouse/Parent Name: _____

How did you hear about us? _____

What made you want to come in? _____

ACCOUNT INFORMATION

Who is responsible for this account? _____

Relationship to Patient: _____

Do you have Dental Insurance? _____

Insurance Company: _____

Phone # _____

Group # _____

Subscriber's Name: _____

Birthday: _____ Member ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to

(Name of Insurance Company)

Dr. _____ all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am finanically responsible for all charges wheter or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my healthcare information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____

Date Relationship to Patient

HEALTH HISTORY

Physician's Name: _____ Date of last physical: _____

Have you ever had any of the following:

Heart Problems	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Blood Pressure Problems	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Radiation Treatment/Cancer	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Other	☐ Yes	☐ No
Hemophilia/bleeding	☐ Yes	☐ No	Fainting/dizzyness	☐ Yes	☐ No	Autoimmune Disease	☐ Yes	☐ No
Respiratory Disease/Asthma	☐ Yes	☐ No	Snoring	☐ Yes	☐ No	HIV/Aids/Other	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Sinus problems	☐ Yes	☐ No			
Headaches (morning especially)	☐ Yes	☐ No	Hepatitis, Jaundice, or Liver Disease	☐ Yes	☐ No			
Excessive daytime sleepiness	☐ Yes	☐ No	Gastroesophageal Reflux Disease (GERD)	☐ Yes	☐ No			
Artificial heart valves or joints?	☐ Yes	☐ No	If yes, what was the date of surgery? _____					
Under the care of a physician?	☐ Yes	☐ No	If yes, for what conditions? _____					
(Woman) Do you suspect that you are pregnant?	☐ Yes	☐ No						
Have you ever taken osteoporosis medication?	☐ Yes	☐ No	How long? _____					

Is there anything else we should know about your medical history? _____

MEDICATIONS

List any medications you are currently taking and why:

ALLERGIES

☐ Aspirin ☐ Iodine ☐ Penicillin

☐ Codeine ☐ Latex ☐ Tylenol

☐ Ibuprofen ☐ Local Anesthetic ☐ Steroids

☐ Other Antibiotics: _____ ☐ Other:

_____

The above information is accurage and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____

Northwood Dental

DENTAL HISTORY

1. Date of last dental visit? ___/___/____ Date of last dental x-rays? ___/___/____
2. Name of previous dentist: _____
3. Reason for today's visit? _____
4. Do you have any concerns about previous dental care or this visit?

   _____
5. Do your gums bleed? *(circle)* Yes☐ No☐
6. Are your teeth loose? *(circle)* Yes☐ No☐
7. Have you ever been told you have gum disease? *(circle)* Yes☐ No☐
8. Have you ever been told you have bad breath? *(circle)* Yes☐ No☐
9. Are your teeth sensitive to? *(circle all that apply)* Sweets☐ Cold☐ Heat☐ Pressure☐
10. Have you ever had pain in your jaw joints (clicking/popping)? *(circle* Yes☐ No☐
11. Are you happy with your smile? *(circle)* Yes☐ No☐

    If no, please explain:_____
12. What would you change about the present condition of your mouth? _____

***

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature:_____ Date: _____

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

Northwood Dental
3023 Eastland Blvd., Suite 112, Clearwater, FL 33761
Financial Arrangements Information For Our Patients

Payment is due in full on the day, and at the time, services are rendered unless different arrangements have been made to pay the balance due, prior to the date of service.

- Should you have dental insurance, we will gladly file your insurance forms for the services provided on the date the services are provided as a courtesy.

- We will **estimate** what your insurance carrier will pay to the best of our ability. This is based upon the information you provide to us. Your insurance policy is a contract between you and your insurance provider. **You will be responsible for any balance that remains unpaid by the insurance company.**

- Our purpose as a dental practice is to help ensure that you have healthy teeth and gums that you can use for a lifetime. Once you establish treatment with your dentist, please be aware that your insurance plan may not cover all of the treatment you require, or may change the treatment according to what is covered by that particular plan, with no real reason to do so. Since the dental insurance company has not seen your mouth, they could not possibly know exactly what you need. Thus, completing only the treatment covered by your plan may be detrimental to your dental health.

My signature below indicates that I have read the above and understand my financial responsibilities:

_____
Print Name (Patient)

_____
Signature (Patient or guardian)

Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on July 8, 2007.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Under the Omnibus Rule, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Under the Omnibus Rule, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you want the copies mailed to you, postage will be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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. **HOW TO CONTACT US:**

Practice Name: Northwood Dental Privacy Officer: Barbara Morin

Telephone: 727-797-5161 Fax: 727-797-5121

Email: officemanager@northwood-dental.com

Address: 3023 Eastland Blvd., Ste 112, Clearwater, FL., 33761

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient file and maintained for six years.

_____

Print Name (Patient)

_____ _____

Signature (Patient) Date

_____ _____

Parent, Guardian or Patients legal Representative Date

_____ _____

Witness Date

I also hereby authorize disclosure of information, via verbal or written communication, regarding appointments, billing, condition, treatment, and prognosis to the following individual(s):

_____ _____

Name Relationship

_____ _____

Name Relationship

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINTED FOR SIX YEARS.

3023 Eastland Boulevard

Suite #112

Clearwater, FL 33761

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient: _____

DOB: _____

Address: _____

THIS WILL AUTHORIZE RELEASE OF DENTAL RECORDS FROM:

Doctor: _____

Address: _____

Phone: _____Fax:_____E-mail_____

I request and authorize the above-names doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED:

☐ Copy of dental x-rays
☐ Other _____

*** If e-mailing x-rays to Northwood Dental, please use e-mail address:**

reception@northwood-dental.com

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED

☐ Transfer of Records ☐ Second opinion

☐ Other, please explain _____

_____ _____

Date Signature of Patient or Parent

VIVOS®

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male ○ Female ○

Have you ever had a sleep test administered? ○ yes ○ no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? ○ yes ○ no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? ○ yes ○ no

Are you happy with your CPAP or Sleep Appliance? ○ yes ○ no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	○	○
Do you habitually snore?	○	○
Have you been diagnosed with Hypertension/High Blood Pressure?	○	○
Do you often suffer from waking headaches?	○	○
Do you regularly experience daytime drowsiness or fatigue?	○	○
Do you have blocked nasal passages?	○	○
Has anyone observed you stop breathing during your sleep?	○	○
Do you ever wake up choking or gasping?	○	○
Do you grind your teeth while sleeping?	○	○
Is your neck circumference greater than 40 cm/ 15.75" ?	○	○
Is your Body Mass Index (BMI) more than 35?	○	○

BMI Formula BMI = (your weight in pounds X 703)

_____

(your height in inches X your height in inches)