DAVID AND ASSOCIATES

Centre for Cosmetic & Implant Dentistry

(904) 268-0606 . 10991-54 San Jose Blvd. Jacksonville, FL 32223

Guest Registration

First Name: ______________________________ Last Name: _____________________ Middle Initial: _____

Address: ________________________________ City: ___________________ State: ____ Zip Code: ______

Home Phone: _________________ Cell Phone:_________________ Work Phone: ____________________

Date of Birth: __________________________ Social Sec. #: _____________________________________

Driver's License Number ____________________________ State: _______ Sex: M or F

Marital Status: Single Married Divorced Widowed Minor

Email: ________________________________ Occupation: ___________________________________

Emergency Contact: ______________________ Relationship: _______________ Phone #: ______________

Preferred Pharmacy: ____ Phone #: ______________

How did you hear about us? (e.g. friend, website, TV, radio)? ______________________________________

Would you like to receive email and text message notifications? Y or N

Responsible Party (if different than guest)

First Name: ______________________________ Last Name: ______________________ Middle Initial: ___

Address: _________________________________ City: ___________________ State: ____ Zip Code: ______

Home Phone: _________________ Cell Phone: _________________ Work Phone: __________________

Date of Birth: ___________________________ Social Sec. #: ___________________________________

Insurance Information

Name of Policy Holder: ____

Patient's Relation to Policy Holder: Self Spouse Child Other

Policy Holder's date of birth: ________________ Policy Holder's SSN: ______________________________

Employer: _____________________________ Insurance Company: ______________________________

Policy/Member #: _______________________ Group #: ______________________________________

Insurance Address: ____

Joel David – Associates, PA

Eaglesoft Medical History

Patient Name:______________________ Date of Birth:______________ Pt ID #:__________________

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.

Question	Answer	
Are you under a physician's care now?	☐ Yes ☐ No	If yes:
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes:
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes:
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes:
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	If yes

Women are you...

☐ Pregnant / Trying to get Pregnant? ☐ Nursing? ☐ Taking Oral contraceptives?

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes: ______________________

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hepatitis A	☐ Radiation Treatments
☐ Alzheimer’s Disease	☐ Diabetes	☐ Hepatitis B or C	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Herpes	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Cholesterol	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Sickle Cell Anemia
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Stomach/intestinal Disease
☐ Breathing Problem	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Osteoporosis	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Pain in Jaw Joints	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Parathyroid Disease	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Psychiatric Care	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease		☐ Venereal Disease
	☐ Hemophilia		☐ Yellow Jaundice

Have you ever had a serious illness not listed above? ☐ Yes ☐ No If yes:______________________

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/ Legal Guardian:

______________________________ Date: __________

<u>**WELCOME TO DAVID AND ASSOCIATES!!**</u>

--------- Centre for Cosmetic & Implant Dentistry --------

OUR MISSION STATEMENT

To provide the highest quality dentistry possible in an environment that allows education and training, excellent customer service and the ability to build confidence and trust while maintaining a high level of respect and integrity.

We are so happy that you have chosen one of the most advanced dental offices in the entire country in both technology and training. We are committed to your oral health and will devise a strategy to maintain your health for years to come. In order for us to attain these results we will need your help. We need to make sure the guidelines of the practice are followed so that your oral health is not compromised.

- We reserve time for just one guest at a time. We do this because we value your time and in turn we must only treat guests that value ours.
- When reserving time at our office please make sure this works for your schedule. Canceled appointments make it impossible to provide you with the level of care and personal attention that we strive for. Canceled appointments, with less than 24 hours' notice, and/or no show appointments, will incur a $45 charge for hygiene appointments, $75 for periodontal treatment and $50/hr. or 10% of scheduled treatment with the doctor, whichever is greater. We will, also, kindly, remind you of your scheduled appointments through text messages and emails, as well as, a friendly call from one of our staff members. If no confirmation is made, the appointment may be subject to cancellation. Furthermore, if three (3) consecutive reservations are missed, we reserve the right to help you find another dentist. Orthodontic appointments: If there are two (2) canceled appointments, with less than 24 hours' notice or two (2) no call/no show appointments, this will void the "free" cleanings, exams and x-rays included in your contract.
- We welcome most dental benefit plans in our office and help you to maximize those benefits. However, please keep in mind that dental insurance is designed to help primarily with preventative care, not extensive treatment.
- It is difficult to tell what your insurance company will cover, and for this reason we will provide you with an ESTIMATE of what your company will provide, NOT a guarantee. Your insurance company may tell you that the charges incurred by you are more than your policy allows, or that it could have been accomplished using less expensive and lower quality alternatives. This is your insurance company's way of limiting your benefits and increasing their profits.
- We have several choices for you to pay for your investment in your dental health. We accept cash, check and all major credit cards. However, if a check fails to clear there is a $25 returned check fee. We also offer Care Credit, Lending Club and Compass Banks unsecured loans specifically designed for medical needs at low monthly payments. We make all of these options available to you because each day's treatment must be paid in full before starting.
- Should any account reach 90 days past due, you will be responsible for all administrative fees associated with the collections process.

It is important that you ask questions. Again, we are not like other offices! You are the only one that we have reserved time for at that moment and we want everything to be clear.

These guidelines are in place to help insure that you receive undivided attention in the development and execution of your personalized dental plan. They allow us to use the latest technology, the best dental technicians and provide personalized attention. Thank you for choosing David & Associates Dentistry, please sign below that you have read the guidelines, agree to them, and have no questions. In stating so, you agree to allow Dr. David and/or his associates to take all necessary radiographs and perform all necessary treatments and procedure that he/they deem necessary. By signing below, you permit us to leave messages for you on your answering machine and/or voicemail. You also acknowledge that you received/reviewed a copy of David and Associates Notice of Privacy Practices, and that it is posted in the office.
By signing below I certify that I have read and understand the information about the Payment Policies for David and Associates Dentistry.

Guest Name: ____

Signature: ____

Date: _____/______/_______

Joel David & Associates P.A.
Practice Manager: Mandi Harris

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name ____

I AUTHORIZE THE PROFESSIONAL OFFICE OF MY DENTIST NAMED ABOVE TO RELEASE HEALTH INFORMATION IDENTIFYING ME (INCLUDING, IF APPLICABLE, INFORMATION ABOUT HIV INFECTION OR AIDS, INFORMATION ABOUT SUBSTANCE ABUSE TREATMENT, AND INFORMATION ABOUT MENTAL HEALTH SERVICES) UNDER THE FOLLOWING HIPPA GUIDELINES.

To whom may the information be released:

Name____Relationship_________________________

Name____Relationship_________________________

Name____Relationship_________________________

NOTE: It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

NOTE: If you sign this authorization, you can revoke it or amend it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

NOTE: When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature___________________________________Dated___________________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Print Name____Relationship to Patient_____________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

David & Associates, Inc.

David & Associates, Inc. is required by law to maintain the privacy of your protected health information (PHI) and to provide individuals with notice of its legal duties and privacy practices currently in effect with respect to PHI. This Notice describes how we may use and disclose your PHI for treatment, payment, and for health care operations as well as for other purposes that are permitted or required by law. 45 CFR § 164.520.

David & Associates, Inc. reserves the right to change the terms of this Notice and make the new notice provisions effective for all the PHI we maintain. If Practice makes a material change to this Notice, we will post the changes promptly on our website at http://www.drjoeldavid.com. A paper copy of this Notice is available upon request.

Effective Date

This Notice of Privacy Practices became effective on April 14, 2003 and was amended on April 6, 2012.

Types of Uses and Disclosures of your PHI

"Treatment" - We will use and disclose your PHI to provide, coordinate or manage your dental health care and any related services. We will also disclose PHI to other providers who may be treating you such as a specialist.

"Payment" - We will use your PHI to obtain payment for the dental health care services provided. For example, we may provide information to a health insurance company or business associate to obtain payment for the treatment provided for you.

"Healthcare Operations" -We will use your PHI to support the management of our dental office. For example, we may use information about you to conduct quality performance reviews regarding our services or the performance of our staff. Additionally, we may obtain services from business associates such as training programs, legal services and insurance.

HITECH Amendments

HITECH Act Breach Notification Requirements: The HITECH Act requires us to notify each individual whose unsecured PHI has been, or is reasonably believed to have been accessed, acquired or disclosed due to a breach. The HITECH Act imposes a similar requirement on Business Associates. "Unsecured "PHI" refers to PHI that is no

secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

Restriction of Disclosure: The HITECH Acts restricts us from refusing an individual's request not to use or disclose the individual's PHI in instances where the patient's services were paid out of pocket to prevent the information from flowing to the health plan since no claim is being made against the third-party payer.

Access to Electronic Health Records (EHRs): The HITECH Act expands the right of records access. Individuals have the right to access their EHR in an electronic format and to direct us to send thee-record directly to a third party. We may only charge for the labor costs to transfer this information.

Expansion of Accounting of Disclosures: The HITECH Act removed the accounting of disclosures exception of PHI to carry out treatment, payment and healthcare operations. All such disclosures must be accounted for if the disclosure is made through an EHR. We also will provide the individual with a list and contact information for all relevant business associates to obtain an accounting of disclosures of PHI.

Prohibition on Sale of PHI: The HITECH Act prohibits covered entities and business associates from receiving indirect or direct remuneration in exchange for PHI without obtain an authorization from the individual unless such an exchange meets one of the exceptions listed by the government.

David & Associates, Inc.'s Responsibilities

Certain Uses or Disclosures: We will use and disclose your PHI when required to by federal, state or local law.

Appointment Reminders: We may contact you to provide appointment reminders via telephone, text message, email or post cards. We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Revocation: Other uses and disclosures will be made only with your written authorization and you may revoke such authorization.

Public Health & Safety: We will use and disclose your PHI to public health authorities permitted to collect or receive information for the purpose of controlling disease, injury or disability.

Individual Rights

Request Restriction of Disclosures: You have the right to request restrictions on certain uses and disclosures of PHI and under HIPAA, David & Associates, Inc. is not required to agree to the restriction unless as clarified by defined by the HITECH Act.

Right to Receive Confidential Communications: You have the right to receive confidential communications. Please specify your preference of communication in

writing to us such as your home telephone, work telephone, mobile telephone, and/ or email. We may provide relevant portions of your PHI to a family member, relative, close friend or any other person you identify as being involved in your dental care or payment.

Right to PHI: You have the right to inspect and copy the PHI that we maintain about you in our designated record set for as long as we maintain the information. We may charge a fee for the costs of copying, mailing or other supplies sued in fulfilling your request. Please contact the Privacy Officer to inspect your record or receive a copy.

Right to Amend: You have the right to request that we amend your health information if you feel it is incomplete or inaccurate. You must make the request in writing to our Privacy Officer stating the reasoning that supports your request. We may deny the request if the information was not created by our office or if the person who created it is no longer available to make this amendment.

Right to Accounting: You have the right to receive an accounting of disclosures of your health information as required by law. Please submit a written request to our Privacy Officer.

Right to Paper Copy: You have a right to obtain a paper copy of the Notice of Privacy Practices.

Request Information or File a Complaint

If you have questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

David & Associates Dentistry
10991-54 San Jose Blvd.
Jacksonville, FL 32223
Tele. (904) 268-0606

front@davidandassociates.net

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our Practice. You may also file a complaint with the Secretary of Health and Human Services at:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW Room 515 F
HHH Building Washington, D.C. 20201
www.hhs.gov/ocr