CHARLES W. MOORE, D.M.D.
JULIANA Y. CHANG, D.M.D.

6025 Memorial Highway • Tampa, FL 33615 • Phone: (813) 886-2527 • Fax: (813) 887-3225

Patient Information (Please Print)

Today's Date: ____________________________

First Name _____________________________________MI ______ Last Name ____

Sex: □M □F Marital Status: □Single □Married □Divorced □Other Date of Birth ___________________________

Social Security # ___________________________________ Driver's License # ____

Address ____

City ____ State _________________ Zip ______________________________

Home Phone (_______)___________________ Work (_______)____________________ Mobile (_______)_____________________

Email Address ____

Student? □No □Yes, School Name ____

Employer Name ____

Employer Address, City, State, Zip ____

Person Responsible for this account _________________Relationship to Patient: □Self □Spouse □Parent □Other ______________

Whom may we thank for referring you to our office? __________________________________

Insurance Information

Primary Insurance Subscriber (if other than patient)

First Name _____________________________________MI ______ Last Name ____

Social Security # ___________________________________ Driver's License # ____

Address ____

City ____ State _________________ Zip ______________________________

Home Phone (_______)___________________ Work (_______)____________________ Mobile (_______)_____________________

Relationship to Patient: □Spouse □Parent □Other _________________________________

Employer Providing Insurance (if other than patient's employer)

Employer Name ____

Address, City, State, Zip ____

Primary Dental Insurance

Company Name ____Phone (___________)____________________________

Policy Number ____ Group Number ____

Address, City, State, Zip ____

Secondary Dental Insurance

Company Name ____Phone (___________)____________________________

Policy Number ____ Group Number ____

Address, City, State, Zip ____

Patient name______________________________________ Today's Date ________________________

Patient Medical/Dental History

Primary Physician's Name & Phone number____ Date of last visit _______________________

Preferred Pharmacy _____________________Address (Cross-roads OK) and/or Phone number: _____________________________________

Emergency Contact ________________________ Relationship to patient ____________________Phone number ___________________________

Are you currently under medical treatment? ☐ Yes ☐ No If yes, please describe____

Have you had any major surgical operations or serious illnesses? ☐ Yes ☐ No If yes, please describe ____________________________________

Please list any medications that you are currently taking, over-the-counter or prescribed: ____

____

Do you take any blood thinners like Warfarin or daily aspirin? ☐ Yes ☐ No If yes, please describe ____________________________________

Do you currently take or have you ever taken any IV or oral bisphosphonate medications (for low bone density, osteoporosis, or cancer) such as Fosamax, Boniva, Prolia, Zometa, Reclast, Actonel, etc? ☐ Yes ☐ No If yes, please describe and for how long? ___________________________

Have you ever had any joints replaced? ☐ Yes ☐ No If yes, please describe ____

Have you ever been advised to take antibiotics prior to any dental procedures? ☐ Yes ☐ No If yes, please describe________________________

Do you use tobacco products including cigarettes, cigars, smokeless/chewing tobacco, or e-cigs? ☐ Yes ☐ No

If so, please describe, and how often/much? ____

Do you use any recreational drugs? ☐ Yes ☐ No If yes, please describe____

Do you use any controlled substances? ☐ Yes ☐ No If yes, please describe____

(Women) Are you pregnant or think you may be pregnant? ☐ Yes ☐ No… Nursing? ☐ Yes ☐ No… Taking oral contraceptive? ☐ Yes ☐ No

Are you allergic to the following:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Local anesthetics	☐	☐	Sulfa drugs	☐	☐	Aspirin	☐	☐
Penicillin / Amoxicillin	☐	☐	Barbituates	☐	☐	Metals	☐	☐
Other antibiotics: ________________	☐	☐	Sedatives	☐	☐	Latex	☐	☐
Codeine or other pain medications	☐	☐	Iodine	☐	☐	Other allergies: __________________________		

Please check if you have/had:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Allergies, hay fever, sinusitis	☐	☐	Emphysema / COPD	☐	☐	Mitral valve prolapse	☐	☐
Anemia	☐	☐	Epilepsy / Seizures	☐	☐	Osteoporosis / Osteopenia	☐	☐
Angina/Chest Pain	☐	☐	Fainting	☐	☐	Pacemaker	☐	☐
Arthritis, rheumatism	☐	☐	Glaucoma	☐	☐	Respiratory problems	☐	☐
Artificial heart valves	☐	☐	Headaches, frequent	☐	☐	Rheumatic fever	☐	☐
Artificial joints / Joint replacement	☐	☐	Heart attack	☐	☐	Sexually Transmitted Disease	☐	☐
Asthma	☐	☐	Heart murmur	☐	☐	Sinus trouble	☐	☐
Bleeding abnormally	☐	☐	Heart problems	☐	☐	Stroke	☐	☐
Blood disease, clotting disorders	☐	☐	Hepatitis type ___	☐	☐	Thyroid problems	☐	☐
Cancer ________________	☐	☐	Herpes	☐	☐	Tonsillitis	☐	☐
Radiation therapy	☐	☐	High / Low blood pressure	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	HIV / AIDS	☐	☐	Tumor or growth on head/neck	☐	☐
Circulation problems	☐	☐	Kidney disease	☐	☐	Stomach troubles/ulcers	☐	☐
Diabetes Type I / II	☐	☐	Liver disease	☐	☐	Weight loss, unexplained	☐	☐

Please explain any "yes" answers listed above **and** list any other medical conditions not addressed above:_________________________________

Do any of the following apply?	**Yes**	**No**		**Yes**	**No**	
Bleeding gums	☐	☐	Orthodontic treatment (present/past)	☐	☐	Main Dental Concern(s):__________________
Sensitivity to hot/cold food or liquids	☐	☐	Frequent biting of lips/cheeks	☐	☐	____________________________________
Sensitivity to sweet food or liquids	☐	☐	Clicking of jaw	☐	☐	____________________________________
Sores/Lumps in or near mouth	☐	☐	Pain from jaw joint, ear, or side of face	☐	☐	____________________________________
Head/neck/jaw injuries	☐	☐	Difficulty opening or closing	☐	☐	____________________________________
Difficult tooth extraction(s) in the past	☐	☐	Difficulty chewing	☐	☐	____________________________________
Prolonged bleeding after extraction	☐	☐	Frequent headaches	☐	☐	
Current or past dentures/partials	☐	☐	Clenching or grinding teeth	☐	☐	Doctor Signature _______________________

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Financial Policy

Our experience has shown us that many questions and/or problems about our financial policies can be avoided by understanding our office policies. As a courtesy, we will be happy to file your primary insurance benefits, though we are not obligated to do so.

Our office policy requires that payment is due in full at the time your dental treatment is rendered. In addition to cash, we accept check, Visa, Mastercard, Discover, and American Express with proper identification. Should you be interested in financing, our office accepts Care Credit 6 month and 12 month interest-free financing. If you are unfamiliar with Care Credit healthcare financing, please ask for details.

Your dental insurance plan is a contract between you, your employer, and the insurance company. Our office does not determine or guideline your benefits. As a courtesy to our patients with dental insurance, our doctors may agree to accept a patient's insurance assignment. If our front desk staff is able to determine the expected coverage of your insurance plan, our office will submit you claim to your insurance company. However, it is your responsibility to be familiar with your insurance policy, including knowledge of your deductibles, yearly maximums, co-payments, and non-covered services. Remaining benefits for pre-treatment estimates are generated on information obtained from your insurance company at the time of inquiry. Moore Dental Care is not responsible for mis-information obtained from your insurance company, including the amount of remaining benefits. We will wait up to 60 (sixty) days for the insurance payment to be received and applied to your account. The responsible party for the account must pay any deductible, co-payments, non-covered services, or difference between the insurance company fees and the office fees at the time services are completed. It is your responsibility to notify the office staff if there are any changes in your insurance coverage.

If, for any reason, your insurance company does not pay the insurance claim or does not pay the full amount of the expected benefit within 60 (sixty) days from the date of service, the balance will be transferred from an insurance balance to a personal balance. A statement will be sent to the responsible party and payment will be expected within 10 (ten) days. Any unpaid balance will be subject to a 1.5% interest rate per month. There will be a $25 service charge on any returned checks. If your account is turned over to a collection agency, you are responsible for any cost incurred in collection of said balance(s), which may include collection agency fees up to 35% of your outstanding balance, court cost, and attorney fees.

An important issue to remember is that the doctor will prescribe dental treatment on the bases of their patient's needs, not on the dental treatment the insurance will or will not cover.

Please sign only after you have read our policy in its entirety and are comfortable with the terms. If you would like a copy of our financial policy, please request one from the front desk after signing. Thank you.

Patient or Guardian Signature ______________________ Date ____________

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Cancellation Policy:

Our office requires notification of at least 1 (one) business day if you need to cancel or reschedule an appointment. Tardiness in excess of 15 minutes may result in a failed appointment if the doctor or hygienist cannot accomodate you in the schedule. Failure to contact our office in advance will result in a $50.00 per half hour fee assessed to your account. The amount of hours is determined by the length of time your appointment was booked for based on your recommended treatment. As a courtesy, your first missed appointment will receive a warning letter since we understand that unforeseen circumstances may arise. Thereafter, the $50.00 per half hour fee will apply.

Signature _______________________ Date _______________

Authorization and Release:

I certify that I have read and answered the questions on the Patient Information Form and Patient Medical History accurately to the best of my knowledge. I understand the information given to me regarding the office's Financial and Cancellation Policies. I understand that withholding or providing incorrect information can be dangerous to my health. I hereby authorize and request the performance of dental services for my child or myself.

I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child or myself during the period of such dental care, to third party payors and/or other health practitioners (i.e. endodontist).

If applicable, I authorize and request my insurance company to pay directly to the dentist or dental group such insurance benefits otherwise payable to me. I understand that I am financially responsible for any deductible, copayments, non-covered services, differences between the insurance company fees and the office fees, or balances unpaid by my insurance company.

I understand that in the event I default on my payment for completed services, I can be charged an amount to cover collection, court, and attorney fees. Initial request of records/x-rays may be obtained with **48 hours** notice. Actual cost of reproducing **written** records is $20.00 an hour for labor and overhead cost, plus postage if necessary per Florida Statute 395.3025. Copies requested for the first 25 pages, the cost shall be $1.00 per page. For each page in excess of 25 pages, the cost shall be $0.25 thereafter.

Patient or Guardian Signature _______________________ Date _______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

____   ______________________________
Signature of Patient or Legal Representative   Date

____   ______________________________
Printed Name of Patient   Legal Relationship to the Patient (*If required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _______________________________ Relationship _______________ Phone_____________

2. Name _______________________________ Relationship _______________ Phone_____________

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is ___________________________________. Please initial _______.

The email address that I authorize to receive email messages for appointment reminders and general health information is ___________________________________. Please initial _______.

Or

_________ **I decline** to receive communications via **text**.

_________ **I decline** to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature____ Date requested: ________________

Reminder** - **Keep information to the minimum necessary and encrypt emails and texts whenever possible

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 take effect on April 14, 2003, and amended September 23, 2013 and 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, Charles W. Moore, D.M.D. 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). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. 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. Lists, if requested, will be $1.00 for each page and the staff time charged will be $20.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

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. Effective March 26, 2013, 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 April 14, 2003.

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. Effective March 26, 2013, 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. Effective March 26, 2013, 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. Copies, if requested, will be $1.00 for each page and the staff time charged will be $20.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also 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. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

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: Moore Dental Care / Curtis R. Moore, D.M.D., P.A. **Privacy Officer**: Charles W. Moore, D.M.D.

Telephone: 813-886-2527 **Fax:** 813-887-3225

Email: Info@mooredentaltampa.com

Address: 6025 Memorial Hwy., Tampa, Florida, 33615