PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
☐ ☐ Are you taking Birth Control Pills?
☐ ☐ Are you pregnant? If Yes, # of weeks ☐
☐ ☐ Are you nursing?

Please answer the following:

Y N
☐ ☐ Do you smoke or use tobacco?

Height: ☐

For Office Use Only
BP ☐ Heart Rate: ☐

Weight: ☐

Y N	Conditions	Y N	Conditions	Y N	Conditions
☐ ☐	Abnormal Bleeding	☐ ☐	Glaucoma	☐ ☐	Stroke
☐ ☐	Alcohol Abuse	☐ ☐	Hay Fever	☐ ☐	Thyroid Problems
☐ ☐	Allergies	☐ ☐	Heart Attack	☐ ☐	Tuberculosis
☐ ☐	Anemia	☐ ☐	Heart Surgery	☐ ☐	Ulcers
☐ ☐	Angina Pectoris	☐ ☐	Hemophilia	☐ ☐	Venereal Disease
☐ ☐	Arthritis	☐ ☐	Hepatitis A	☐ ☐	Yellow Jaundice
☐ ☐	Artificial Bones	☐ ☐	Hepatitis B		
☐ ☐	Artificial Heart Valve	☐ ☐	High Blood Pressure		
☐ ☐	Asthma	☐ ☐	HIV+ AIDS	Y N	**Allergies**
☐ ☐	Blood Transfusion	☐ ☐	Kidney Problems	☐ ☐	Aspirin
☐ ☐	Cancer- Chemotherapy	☐ ☐	Liver Disease	☐ ☐	Codeine
☐ ☐	Colitis	☐ ☐	Low Blood Pressure	☐ ☐	Dental Anesthetics
☐ ☐	Congenital Heart Defect	☐ ☐	Mitral Valve Prolapse	☐ ☐	Erythromycin
☐ ☐	Cosmetic Surgery	☐ ☐	Pace Maker	☐ ☐	Jewelry
☐ ☐	Diabetes	☐ ☐	Pneumocystitis	☐ ☐	Latex
☐ ☐	Difficulty Breathing	☐ ☐	Psychiatric Problems	☐ ☐	Metals
☐ ☐	Drug Abuse	☐ ☐	Radiation Therapy	☐ ☐	Penicillin
☐ ☐	Emphysema	☐ ☐	Rheumatic Fever	☐ ☐	Tetracycline
☐ ☐	Epilepsy	☐ ☐	Seizures		**Other**
☐ ☐	Fainting Spells	☐ ☐	Shingles		________
☐ ☐	Fever Blisters	☐ ☐	Sickle Cell Disease		________
☐ ☐	Frequent Headaches	☐ ☐	Sinus Problems		________

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above?**
If yes, please describe below...

Notes:

Signature: ______________________________ **Date:** ______________

(If Under 18, Parent or Guardian Signature Required)

Dianne M. Busch, DMD, PA
Cosmetic and Restorative Dentistry

7733 W. Newberry Road, Suite B-3
Gainesville, FL 32606

PATIENT CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION – A: PATIENT INFORMATION

Name: ___________________________________ Relation to Patient: ____________________

Address: ____

Telephone: ______________________________ Email: _________________________________

Social Security #: ______________________________ Patient #: __________________________

SECTION – B: TO THE PATIENT – PLEASE READ CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry-out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. Our notice provides a description of our treatment, payment activities, and healthcare operations, and the uses and disclosures we may make of your protected health information. A copy of our notice accompanies this consent form, and we strongly recommend you read it carefully, and understand it completely, before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, any time by contacting:

Contact Officer: Dr. Dianne Busch
Telephone: (352) 331-4700
Address: Gainesville, FL 32606

Right to Revoke: Your will have the right to revoke this consent at any time by giving us notice of your revocation, which shall be submitted to the person listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you, or to continue treating you, if you revoke this consent. In such a case, you will be given 30-days written notice to seek the care of another health care professional, and request a transfer of records.

SECTION – C: PATIENT SIGNATURE

I, ___________________________________, have taken full opportunity to read and consider the contents of this consent form, as well as your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my full consent to your use and disclosure of my protected health information to carry out all treatment, payments and related health care operations.

SIGNATURE: ____ DATE: ___________________

RELATION TO PATIENT: ______________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER SIGNING IT.

Dianne M. Busch, DMD, PA
Cosmetic and Restorative Dentistry

7733 W. Newberry Road, Suite B-3
Gainesville, FL 32606
(352) 331-4700

OFFICE FINANCIAL POLICY

1. As a courtesy, this office will file insurance claims for you. **Payment is expected at the time of service**, including all estimated co-payments, deductibles and fees not reimbursed by your insurance carrier. Please indicate which of the following financial options you will be using:

   ☐ Cash ☐ Personal check ☐ Financing plan

   ☐

2. Your final co-payment will be determined by your:
   - Actual insurance benefit paid
   - Your defined insurance discount savings as specified in your Explanation of Benefits schedule returned to us

3. We ask your consideration when scheduling appointments. Please be absolutely sure you intend to keep your appointment time. **Failure to notify us of a cancellation a full 24 hours before your appointment time by speaking to a staff member will result in a $35 administrative charge.**

4. Any quotes given by this office and staff are only an estimate and do not guarantee any payments by your insurance carriers. This office will submit your claim and will resubmit it only once, on your behalf. If payment is not received within 30 days from date of service, it is your responsibility as the member to call your insurance carrier and collect the money due for the service provided for you.

5. If your insurance carrier does not authorize payment for a service and you choose to have the service performed anyway, payment is required up front. Your insurance cannot be billed for those services.

I understand that I am personally responsible for payment of all services rendered. I authorize and direct payment of the dental insurance benefits otherwise payable to me, directly to Dianne M. Busch, DMD, PA.

Patient Signature ___________________________________ Date _________________

Dianne M. Busch, DMD, PA
Cosmetic and Restorative Dentistry

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Gainesville, FL 32606

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _______________________________________, have received a copy of this Dental office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but this could not be obtained, because:

____ Individual refused to sign this form

____ Communications barriers prohibited us from obtaining the acknowledgement

____ An emergency situation prevented us from obtaining the acknowledgement

____ Other (please specify)

_

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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 upon request. Please review this information carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by federal & state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on April 4, 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 changes are permitted by the applicable federal & state laws. We reserve the right to make changes in our privacy practices, and the new terms of our notice, effective for all health information that we maintain, including the health information that we created or received before we make such changes. Nonetheless, before we make a significant change in our privacy practices, we will change this written notice, and make the new written 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 written notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use and disclose your health information to a physician or other healthcare provider giving treatment to you.

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

Healthcare Operations: We may use and disclosure your health information in connection with our healthcare operations. Healthcare operations may include quality assessment & improvement activities, reviewing competence & qualifications of healthcare professionals, evaluating practitioner & provider performance, conducting training program accreditation, certification, licensing and credentialing activities.

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

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

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

Marketing Health-Related Services: We will not use your health information for marketing communications, without your written consent.

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

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

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

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

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PATIENT RIGHTS

Access: You have the right to look at, or obtain copies of your health information, with limited exceptions. You may request that we provide copes in a format other than photocopies. We will use the format you request, unless we cannot practically do so.

You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $20 for staff time, printing and postage. If you request an alternative format, we will charge a reasonable fee for providing your health information in that alternative format.

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates, have disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the past 6 years. If you should request this record accounting more than once in a 12 month period, we may charge you a reasonable fee for responding to these additional requests.

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

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

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

Electronic Notice: If you receive this notice on our website or by email, then you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services; we will provide an address 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 to the U.S. Department of Health and Human Services.

CONTACT INFORMATION

Contact: Dr. Dianne M. Busch
Telephone: (352) 331-4700
Fax: (352) 331-4743
Address: 7733 W. Newberry Rd, Ste B-3
Gainesville, FL 32606