Welcome to Coastal Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill these forms as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining you dental health.

Patient Information

Name_____ Soc. Sec. #_____-_____-_____
Last Name First Name M.I.
Address_____
City_____ State_____ Zip code_____
Cell # _____ Home #_____ E-Mail_____
Sex M or F Age_____ DOB_____ Circle one - Single Married Widowed Separated Divorced
Employment_____ Occupation_____
Business Address _____ Business # _____
Who may we thank for referring you? _____
Notify in case of emergency? _____ Phone # _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name M.I.
Relation to Patient_____ Birthdate_____ Soc. Sec. #_____
Address (*if different from patient*) _____
City_____ State_____ Zip code_____
Cell # _____ Home #_____ E-Mail_____
Person Responsible Employed by _____ Occupation_____
Business Address _____ Business # _____
Insurance Company_____ Phone# _____
Group # _____ Subscriber #_____
Names of other dependents under this plan_____

Additional Insurance

Person Responsible for Account _____
Last Name First Name M.I.
Relation to Patient_____ Birthdate_____ Soc. Sec. #_____
Address (*if different from patient*) _____
City_____ State_____ Zip code_____
Cell # _____ Home #_____ E-Mail_____
Person Responsible Employed by _____ Occupation_____
Business Address _____ Business # _____
Insurance Company_____ Phone# _____
Group # _____ Subscriber #_____
Names of other dependents under this plan_____

Medical/Dental History Form

For the following questions, please circle **YES** or **NO**, whichever applies. Your answers are for **OUR** records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Dental History

What would you like us to do today? _____ Are you in any pain? _____
Former Dentist_____ Address_____
Former Dentist # _____ Date of last dental care _____
Date of last X-Ray_____

Bad breath	**Yes/No**	Clicking or popping jaw	**Yes/No**	Periodontal treatment	**Yes/No**
Bleeding Gums	**Yes/No**	Food collection between teeth	**Yes/No**	Grinding or clenching teeth	**Yes/No**
Sensitivity to hot	**Yes/No**	Loose teeth or broken fillings	**Yes/No**	Sensitivity to sweets	**Yes/No**
Sensitivity to cold	**Yes/No**	Sensitivity to when biting	**Yes/No**	Sores or growths in mouth	**Yes/No**

How often do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes/No
Other information about your dental health or previous treatment? _____

Medical History

Height_____ Weight_____Lbs.

Are you currently under a physician's care? **Yes / No**

If so, what condition is being treated? _____

Name and Address of Physician _____

Pharmacy name and phone number_____

Are you allergic to or have you had a reaction to any of the following…..

Aspirin	Y/N	Latex	Y/N
Barbiturates, sedatives Or sleeping pills	Y/N	Amoxicillin or other antibiotics	Y/N
Codeine	Y/N	Sulfa drugs	Y/N
Iodine	Y/N	Other	Y/N
Local anesthetics	Y/N	List _____	

For the following questions, please circle **(*Y*) *YES*** or **(*N*) *NO***, whichever applies.

AIDS/HIV positive	Y/N	Food allergies	Y/N	Respiratory disease	Y/N
Abnormal bleeding	Y/N	Glaucoma	Y/N	Rheumatic/Scarlet fever	Y/N
Anaphylaxis	Y/N	Heart murmur	Y/N	Shingles	Y/N
Anemia	Y/N	Heart problems	Y/N	Shortness of breath	Y/N
Arthritis	Y/N	Describe _____		Skin Rash	Y/N
Artificial heart valves	Y/N	Herpes	Y/N	Spina Bifida	Y/N
Artificial joints	Y/N	Hepatitis	Y/N	Stroke	Y/N
Asthma	Y/N	High blood pressure	Y/N	Surgical implant	Y/N
Atopic (allergy prone)	Y/N	Jaw pain	Y/N	Swelling of feet/ankles	Y/N
Back problems	Y/N	Kidney disease		Thyroid disease	
Blood disease	Y/N	malfunction	Y/N	or malfunction	Y/N
Cancer	Y/N	Chemotherapy	Y/N	Tonsillitis	Y/N
Chemical dependency	Y/N	Liver disease	Y/N	Tuberculosis	Y/N
Circulatory	Y/N	Material allergies			
Cortisone	Y/N	(latex, wool, metal, chemicals)	Y/N	Ulcer/Colitis	
Cough, Persistent	Y/N	Mitral valve prolapse	Y/N	Venereal disease	Y/N
Cough up blood	Y/N	Pacemaker/Heart surgery	Y/N		
Diabetes	Y/N	Psychiatric care	Y/N		
Epilepsy	Y/N	Rapid weight loss/gain	Y/N		
Fainting	Y/N	Radiation treatment	Y/N		

Do you smoke or use tobacco products? **Y/N**

If so how much and how often_____

Do you drink alcoholic beverages? **Y/N**

If so how much and how often_____

Do you have any disease, condition, or problem not listen above that we should know about? **Y/N**

_____

Are you wearing removable dental appliances? **Y/N**

<u>Female patients only</u>

Are you pregnant?	Y/N
Are you nursing?	Y/N
Are you taking birth control	Y/N

Remember, this is for "Our" office only- information is not shared at all.

Please list any medications you are currently taking prescription, over the counter, herbal or marijuana use.

_____

_____

_____

I certify that I have read understand the above, I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any of his staff, responsible for any errors or omissions that I may have made in the completion of this form, and I understand the HIPPA regulatory laws.

_____ _____

Signature of patient/guardian **Relationship to patient**

Coastal Dental Group

POLICIES

*****Please read this document thoroughly and sign your name at the bottom. By signing this document you acknowledge that you were informed of these policies*****

Cancelation Policy: Unlike many medical/dental offices, we do not book multiple patients at the same time! Many offices do this to the high cancelation rate, forcing the patient to wait a substantial amount of time before seeing the provider. We believe that your time is just as valuable as our, therefore we expect that when an appointment is booked, the patient keeps the appointment. In our office, **if we do not receive notice of cancelation 24 hours in advance, the patient is charged $50.00 per ½ hour booked in the schedule!** Initial x_____

Financial policy: Our office requires payment at the time of service. If you have an insurance plan that we accept, we will submit a claim and bill them directly for reimbursement on your behalf, but require that your co-pay for the treatment is paid on the date the treatment is performed. **If for any reason your insurance company does not pay for any part of your claim you as the patient are fully responsible for any outstanding balances remaining. The treatment plan provided to you by our office is just an estimation and is not a guarantee of payment. Should you request a pre-determination from your insurance company our office will do so for you at no additional charge. However a pre-determination is not a guarantee of payment and if your claim is denied for any reason you as the patient are fully responsible. We require a deposit (50% of the co-pay) at the time the appointment is scheduled for new patients.** Initial x_____

Warranty: Professional dental cleanings/exams are a crucial part in maintaining the health of your teeth and gums. **Removal of plaque and tartar is essential in maintaining a healthy mouth. As always, we taper your treatment to what is best for you and not your insurance company!** If you do not receive a professional cleaning every 3/6 months (based on what your provider recommends), you are susceptible to: gum disease (bone loss around the teeth, bleeding gums and bad breath), cavities (decay on the tooth structure due to bacteria), plaque and tartar sitting on the teeth, root canals from extensive decay, crowns and eventually loss of the tooth completely! If you are diagnosed with gum disease and do not receive the necessary treatment, most insurance companies will not pay benefits on any restorative treatment you may need until the gum disease is treated. **Dr. Zicchino guarantees his work up to 2 years ONLY if you treat your gum disease accordingly and/or receive your regularly scheduled cleanings!** By signing this form you understand that if your dental treatment falls due to poor oral hygiene and/or not adhering to your recommended dental visits, it is your responsibility to have your work re-done or alternative treatment completed! Initial x_____

Print Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Coastal Dental Group

Acknowledge of Notice of Privacy Policies

You may refuse to sign this acknowledgement

I, _____ have been informed of this office's Notice of Privacy Practices.

_____

Patient Signature Date

_____

For Office Use Only

We attempted to obtain written acknowledgment that the patient was informed of our Notice of Privacy Practices; acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining the acknowledgement
( ) Other-Please Specify: _____
_____
_____

Patient Agreement

Regular dental cleanings/exams are crucial in preventing dental disease and maintaining restorative dental work

Professional teeth cleaning, which is sometimes referred to as a prophylaxis, is intended to remove excess tartar, calcium deposits or calculus as well as plaque (sticky film with bacteria) from your teeth, leaving them smooth, cleaned and polished. By cleaning and polishing the surface of your teeth, the hygienist is removing any rough and sticky areas along your gums, thereby preventing bacteria from attaching and growing there and causing gum disease and bone loss.

We strive to keep and achieve healthy teeth and gums for life with all of our patients, but we cannot do it alone. You, the patient must keep your teeth and gums clean and healthy in order for your treatment to be successful! Maintaining excellent at home oral hygiene (flossing daily, brushing and rinsing with Listerine) as well as your necessary professional dental cleaning regiment (every 3/6 months) is the only way your teeth and gums can stay healthy, decay and bacteria free!

You must acknowledge and understand that if your dental treatments fail i.e. (implants, crowns and bridge) due to poor oral hygiene (tartar and plaque present on or around the implant/crown/bridge, decay under/around the bridge) and are not adhering to your recommended professional cleaning schedule, it is your responsibility to have your work re-done or alternative treatment done. Most insurance plans will not pay for restorative work until the mouth is free from infection/gum disease!

I attest that I have read and understand the patient agreement.

Patient Signature Date

Jaw Joint (TMD) Questionnaire

Instructions:

1. Please check off on the list below any of the following that you may have.
2. Then rate your complaints for frequency and intensity:
   Frequency:
   (1-SELDOM, 2-OCCASIONAL, 3-FREQUENT or 4-EVERYDAY)
   Intensity:
   (0-**NO PAIN** AND 10-**MOST SEVERE PAIN**)
3. Please explain if you checked yes to any of the following.

Number	**Frequency**	**Intensity**
___ Back Pain	___	___
___ Dizziness	___	___
___ Ear Congestion	___	___
___ Ear Pain	___	___
___ Eye Pain	___	___
___ Facial Pain	___	___
___ Fatigue	___	___
___ Headaches	___	___
___ Inability to Open Mouth	___	___
___ Jaw Clicking	___	___
___ Jaw Joint Noises	___	___
___ Jaw Locking	___	___
___ Jaw Pain	___	___
___ Limited Mouth Opening	___	___
___ Migraine Headaches	___	___
___ Muscle Twitch	___	___
___ Neck Pain	___	___
___ Pain with Chewing	___	___
___ Ringing in the Ears	___	___
___ Shoulder Pain	___	___
___ Throat Pain	___	___
___ Visual Disturbances	___	___

Please Explain:

_____

_____

_____

_____

Signature Date

Coastal Dental Group

YOUR COPY OF OUR

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 CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL OBLIGATION

We are required by applicable federal and 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's on effect. This notice takes effect 8-1-2004, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by applicable law. 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 changes. Before we make a significant change in our privacy practices, we will change the 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 practice or for additional copies of the 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 your treatment, payment and healthcare operations. For example:

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

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

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the

competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or 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 us 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's in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the notice.

To Your Family and 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, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 insurance.

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

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, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or 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 authorization federal officials health information required for lawful intelligence counter-intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of 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).

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 obtain a form to request access by using the contact information listed at the end of notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. 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 $2.00 for each page and postage if you want the copies mailed.
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 will 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 a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. 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 request.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosures 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).
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.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under 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 deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

<u>Questions and Complaints</u>
If you want more information about our privacy practices or have questions or concerns please contact us. If you are concerned that 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 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.