PAUL HORTON, DMD, PA

WELCOME TO OUR OFFICE

DATE: _____

PATIENT NAME: (first, middle, and last) _____

HOME ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

HOME PHONE: _____CELL: _____WORK: _____

EMAIL ADDRESS: _____

BIRTH DATE: _____SEX: _____Female _____Male

MARITAL STATUS: _____Single _____ Married _____Divorce _____Widow(er)

EMPLOYER: _____OCCUPATION: _____

PATIENT SOCIAL SECURITY #: _____

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE PREVIOUSLY? _____yes _____no

IF YES, WHO? _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____GROUP: _____

SUBSCRIBER'S NAME: _____SOCIAL SECURITY #: _____

BIRTH DATE: _____RELATIONSHIP TO PATIENT: _____

WE WILL NEED TO MAKE A COPY OF YOUR DENTAL INSURANCE CARD

IF PATIENT IS A MINOR, OR HAS A POWER OF ATTORNEY, PLEASE FILL OUT THE FOLLOWING INFORMATION:

NAME OF RESPONSIBLE PARTY AND RELATIONSHIP: _____

ADDRESS: _____

PHONE: _____

1. I authorize Dr. Horton to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Horton choose and employ such assistance as deemed fit to provide recommended treatment.
2. I understand that it is my responsibility to advise Dr. Horton's office of any changes in the information contained on this form.

Signature: _____Date: _____

PAUL HORTON, DMD, PA - DENTAL HISTORY

Patient Name:_____Date_____

What is the reason for your visit today? _____

_____

Date of last dental visit _____Last dental cleaning _____Last full mouth X-Rays_____

How often do you have dental examinations? _____

How often do you brush your teeth? _____How often do you floss? _____

Have you ever used or are currently using topical fluoride? _____ Yes _____ No _____

Do you have any dental problems now? _____ Yes _____ No _____

If yes, please describe _____

Please check any of the following which apply in either past or present:

___Hot or cold sensitivity

___Sweets sensitivity

___Biting or chewing sensitivity

___Experience bad odors or bad tastes

___Frequent cold sores, blisters, or other lesions

___Bleeding gums

___Painful gums

___Experienced gum disease

___Have tooth loss

___Loose teeth

___Change in your bite

___Food catches between your teeth

___Clench or grind teeth while **awake**

___Mouth breathe while awake or asleep

___Snore or other sleeping disorders

___Smoke or chew tobacco-packs/cans per day___

___Orthodontic treatment

___Oral surgery

___Periodontal treatment

___Your teeth ground or bite adjusted

___Received a mouth guard

___Clicking or popping jaw

___Difficulty opening / closing mouth

___Difficulty chewing on either side of mouth

___A serious injury to the mouth or head

___Clench or grind teeth while **asleep**

___Bite lips or cheek regularly

___Family history of tooth loss

Are you satisfied with your teeth's appearance? _____ Yes No_____

Would you like to keep all of your teeth all of your life? _____ Yes No _____

Do you feel nervous about dental treatment? _____ Yes No _____

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? _____

Paul Horton, DMD, PA

MEDICAL HISTORY

Patient Name:_____**Date**_____

Emergency Contact Name:_____**Phone**_____

Please **CIRCLE** any of the following which you have or have had in the past

Do you require antibiotics before dental treatment? Y N **PRE-MED DOSAGE**_____

Your current physical health is: _____Excellent _____Good _____Fair _____Poor

Y N **Heart Conditions** (Murmur, Rheumatic heart disease, Congenital defect, Mitral valve prolapse, Heart attack, Coronary artery disease, Irregular heartbeat, Congestive Heart failure, etc)

Y N **Chest Pain** (Angina)

Y N **Heart Procedures** (Stents, Catheterization, Angioplasty Pacemaker, Bypass surgery, Valve replacement)

Y N **Stroke or TIA's**

Y N **High Blood Pressure**

Y N **Blood Transfusions** Date _____

Y N **Blood disorders** (anemia, bleeding tendencies)

Y N **Stomach or Intestinal disease** (GERD, Ulcers, Colitis Diverticulitis, Hernia, Hiatal hernia)

Y N **Diabetes** (or family history of) A1C Level _____

Y N **Cancer, Tumor, or Growths** (include skin, benign) _____

Y N **Radiation therapy** (X-ray treatments for Cancer)

Y N **Fainting spells or Vertigo**

Y N **Frequent headaches or earaches**

Y N **TMJ** (Jaw joint) problems or limited opening of mouth

Y N **Organ Transplants** _____

Y N **Kidney Disease or Stones**

Y N **Autoimmune disease** such as Lupus, Pemphigus Pemphigoid, Lichen Planus

Y N **Pregnant or breast feeding** currently (Women only)

Y N **Glaucoma**

Y N **Thyroid Disease**

Y N **Liver Disease** (Cirrhosis, Hepatitis)

Y N **Respiratory Disease** (Emphysema

Y N **Cortisone or steroid type meds**

Y N **Prosthetic Joints or Valves** (Hip Replacements)

Y N **Seizure Disorder** (Epilepsy)

Y N **Arthritis** (Rheumatoid, Osteo, Fibromyalgia)

Y N **Allergies** (Seasonal, foods, materials, medication)

Y N **Sinus Problems**

Y N **Loss of Weight** (without dieting)

Y N **History of Surgery,** especially several repeated procedures in childhood

Y N **Are you allergic to** or unable to eat bananas, kiwi, avocadoes, tomatoes, potatoes, chestnuts?

Y N **Do you have a heavy persistent cough** of 2-3 weeks duration, particularly one that brings up sputum or bloodied sputum?

Y N **Infectious disease** (AIDS, Herpes, Syphilis, Tuberculosis, Hepatitis A,B,C, or other)

Y N **Substance abuse** (alcohol, cocaine, drugs, etc)

Y N **Smoke or chew tobacco**

Packs per day _____ Cans per day _____

Y N **Are you past Menopause** (Women only)

MEDICAL/DENTAL HISTORY Patient Name:_____

Please list all physicians and their specialty:

Family Physician: _____ Physician:_____

Phone: _____ Specialty: _____

Address:_____ Phone: _____

Date of Last Visit: _____ Address: _____

Date of Last Visit: _____

Physician: _____ Physician: _____

Specialty: _____ Specialty: _____

Phone: _____ Phone: _____

Address: _____ Address: _____

Date of Last Visit: _____ Date of Last Visit: _____

Please list any current medications you are taking and reason. Include prescription, supplements, and over-the-counter.

Name of Medication	Dosage	Reason

Have you ever experienced an allergic or unusual reaction to any of the following?

_____Aspirin	_____Sulfa drugs	_____Penicillin	_____Erythromycin
_____Tetracycline	_____Barbiturates	_____Pain Medication	_____Acetaminophen
_____Ibuprofen	_____Latex	_____Local anesthetic (Novocain)	_____Codeine

Please list any other drug or materials that you are allergic to: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during the diagnosis and treatment with my informed consent.

_____

Signature Date

PAUL HORTON, DMD, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices

_____

Please Print Name

_____

Signature

_____

Date

……..

OFFICE USE ONLY

……

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,

But acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ Emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify)

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 IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

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 is in effect. This Notice takes effect **September 20, 2018,** 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 applicable law. We reserve the right to make changes I 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 the changes. Before we make a significant change in our privacy practices, we will change this 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 providing 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 disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications or healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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 information to notify, or assist in the notification of (including 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 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 emergency circumstances, we will disclose health information based on 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 information.

Marketing Health-Related Services: We will not use your health information for marketing communication 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 authorized federal officials health information required for lawful intelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials.

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 this 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 $.10 for each page, and $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure 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.)

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 Website or by electronic mail (email) 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. You may file a complaint by using the contact information listed at the end of this Notice. You 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.

Contact Officer: Karla Horton, RDH

Phone: (863) 471-1727

Email: paulhortondmd@comcast.net

Address: 4229 Sebring Parkway, Sebring, FL 33870

Paul Horton, DMD, PA

How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your name: _____

Today's Date:_____

Check or complete all that apply (please print clearly):

_____Contact me by U.S. Mail at the following address:

_____

_____Contact me by email at the following email address:

_____

For Phone and Text Communications:

This form is optional. You are not required to sign this form, and you do not need to sign it to receive care in our dental office.

Phone Number:_____

_____**By checking here, I consent to the following:** The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

_____Call me

_____Text me

_____Call me and text me

Signature:_____Date:_____