WELCOME to Palmetto Dental the office of Benjamin J. Grooters, DDS

It is our pleasure to welcome you to our practice. Please fill out this form as completely as possible so that we may get to know you and serve your dental needs. We will be happy to help you with any questions if you need assistance.

PATIENT INFORMATION

Full Name _____ Preferred_____Address_____

City _____State _____ ZIP_____ Whom may we thank for referring you? _____

Sex: ( ) Male ( ) Female Status: ( ) Married ( ) Single ( ) Widowed Date of Birth ____/_____/____Social Security #_____

Employer_____ Home Phone_____

Cell _____ Work_____ EXT_____ Email_____

Your preferred method(s) for the office to notify you of your appointments: ( ) Text ( ) Email ( ) Cell ( ) Home ( ) Other_____

In case of emergency, who should we contact? _____Phone (___)_____Relationship _____

INDIVIDUAL RESPONSIBLE FOR FINANCIAL ACCOUNT(If different than above)

Name _____ Relationship _____Social Security #_____

Address_____ City _____

State _____ ZIP_____ Date of Birth ____/_____/____Home Phone_____

Cell_____ Work_____

DENTAL INSURANCE INFORMATION FOR YOUR REIMBURSEMENT

Insured Party_____ Relationship_____ Subscribers SS#_____

Telephone_____ Date of Birth ____/_____/____ Address_____

City _____State ____ ZIP_____Employer_____

Ins. Co. Name_____ Telephone_____ Group #_____

Ins. Company Address_____ Subscribers ID# _____ Please provide our office with a copy of card if available & a copy of your ID

DENTAL CONCERNS

Reason for your visit _____

Which do you consider most important? ___Preserving Natural Teeth ___Eliminate Pain ___Attractive Smile ___Eliminate Infection

What is your reaction to having dental treatment? Enjoy the experience ___Do not mind it ___Dread it ___Worry about it

When was your last dental appointment? _____ Purpose of last dental appointment? _____

How often do you brush your teeth? _____ Floss? _____ Texture of toothbrush? __Soft __Med __Hard

Do you use an electric or manual toothbrush? _____

How would you rate your smile? (1 – 10) (1) being worst) _____ Would you like your teeth to be whiter? Yes No

Please check any of the following habits, conditions or concerns you have:

[ ] bleeding gums [ ] missing permanent teeth [ ] appearance of teeth [ ] sensitive teeth [ ] facial muscle pain
[ ] tender or swollen gums [ ] clinch or grind teeth [ ] existing cavities [ ] tired jaws [ ] broken teeth or fillings
[ ] frequent headaches [ ] gag easily [ ]"sweet tooth" [ ] history of gum surgery
[ ] chew ice [ ] chew hard crunchy foods [ ] history of radiation or chemotherapy for cancer related problems

Patient or guardian signature X_____

MEDICAL HISTORY

Are you currently under the care of a physician? [ ] Yes [ ] No Physician's Name: _____ Phone # _____

For what condition are you being treated? _____

Have you ever been treated for cancer with radiation or chemotherapy? [ ]Yes [ ]No If so when and what area? _____

Are you allergic to medications, latex gloves, local anesthetics, etc.? _____ List allergies _____

Please list any other medical problems you may have or have had in the past_____

Pharmacy of choice: _____Pharmacy Phone #_____

Does your medical history include any of the following conditions?

[ ] AIDS	[ ] Anemia	[ ] Arthritis	[ ] Artificial joints	[ ] Blood disease	[ ] Cancer
[ ] Dizziness	[ ] Epilepsy	[ ] Fainting	[ ] Glaucoma	[ ] Hay fever	[ ] Excessive bleeding
[ ] Head injury	[ ] Heart Murmur	[ ] Hepatitis	[ ] Jaundice	[ ] Stroke	[ ] High blood pressure
[ ] Liver disease	[ ] Tumors	[ ] Mental disorders	[ ] Nervous disorders		[ ] Currently Pregnant (___ Months)
[ ] Respiratory problems		[ ] Sinus problems	[ ] Stomach problems		[ ] Radiation treatment
[ ] Kidney disease		[ ] Tuberculosis	[ ] Diabetes		[ ] Dementia

[ ] Other _____

LIST MEDICATIONS YOU ARE PRESENTLY TAKING:

Medication Name	Reason for Taking Medication

(If additional space needed please put back of this sheet)

OFFICE POLICIES AND CONSENT

1. I hereby authorize the doctor to take necessary x-rays, study models, photographs, or any other diagnostic aid deemed appropriate.
2. I understand that quality dental care is often a result of several professionals, both general dentists and specialists, working together as a team to provide the best care for the patient. I understand this form and all information may be shared with any member of said team.
3. I understand that each appointment scheduled is time specifically reserved and in the event of any changes I will give the office a minimum of 48 hour notice.
4. I understand the use of anesthetic agents embodies a certain level of risk.
5. In case of a medical emergency, I authorize the doctor to perform any and all forms of treatment, medications and therapy that may be indicated and further authorize the doctor to choose and employ such assistance as he deems fit.
6. The patient is fully responsible for all fees incurred. Fees are due and payable at the time services are rendered.
7. I understand that a 1.5% per month charge (18% annually) will be added to any overdue balance. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and attorney fees as may be required to effect collection of this note.
8. Patients with Dental Insurance: I understand that dental insurance is a contract between the patient and their insurance company and not between the insurance company and the doctor. All professional services rendered are charged to the patient and they are personally responsible for payment of all fees. Please remember that insurance is considered a method of reimbursing the patient for fees charged and is not a substitute for payment. Some companies pay fixed allowances for procedures, others pay a percentage of fees and some send payment only to the patient. To determine the method of reimbursement by your insurance company, the patient is responsible to pay for all appointments until your initial insurance claim is paid. At that time this office may agree to estimate the patient's co-pay, which is due as services are rendered, and accept payments from your insurance company. Any unpaid estimated balance will be billed to the patient. It is the patient's responsibility to pay any deductible amounts or any balance not paid by your insurance company.

This signature on file is my authorization for the release of information to process insurance claims. Additionally, **to the best of my knowledge, all of the preceding answers and information provided are true and correct. In the event of a change in the above information, I will inform this office so that my records can be updated. I have read the consent and office policies above and agree and will abide with the content.**

_____X_____ _____

Print Name Signature of Patient (Parent or Guardian if minor) Date

Patient Appointment Policy

Your dental health is important to us! Providing services in a timely manner is critical to assisting you in reaching your dental goals. One of our objectives is to keep the cost of dental services as economical as possible. Each appointment you schedule is time reserved specifically for you and your treatment. When a patient fails to keep their appointment the cost of rendering dental care increases and this additional cost is ultimately passed on to all patients by increasing all fees. Therefore it is the patient's ultimate responsibility to keep their scheduled appointment or provide adequate time (two working days) for the scheduling coordinator to move another patient into the time that was previously reserved for you.

A broken appointment is a loss to three people:

- The patient who missed the valuable time
- Another patient who could have used the valuable time reserved for you
- The dentist whose trained professionals/facilities are not being utilized

For these reasons, if a patient fails to keep an appointment he or she will be charged a fee of $100.00/hour scheduled.

This practice considers a broken appointment to be:

- A change of an appointment without the customary advance 48 hour notice
- If a patient does not show up at all
- If a patient shows up 15 minutes past the appointment time without notice.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask.

I have read and understand the above mentioned policy. X_____ Date _____

Patient's signature (Parent or Guardian if minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received (Page 5 of the form) a copy of this office's Notices of Privacy Practices
Patient's Name

AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The individuals who may use or disclose this information are Dr. Benjamin J. Grooters and staff as well as any healthcare provider to whom the patient is referred to by Dr. Grooters

LIST OF INDIVIDUALS WHO MAY RECEIVE AND USE DISCLOSED INFORMATION

NAME _____ RELATIONSHIP_____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

PLEASE SPECIFY WHAT TYPE OF INFORMATION CAN BE DISCLOSED TO ABOVE INDIVIDUALS

[ ] ALL INFORMATION [ ] APPOINTMENT INFORMATION [ ] FINANCIAL INFORMATION

[ ] MEDICAL RECORDS [ ] X-RAYS [ ] PERSONAL IDENTIFYING INFORMATION

[ ] INSURANCE INFO. [ ] OTHER (SPECIFY)_____

Patient's Signature X_____ Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but 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 (Specify)_____

Staff's Signature X_____

Please Keep This Copy for Your Records

The following information is your copy of the current rules and regulations regarding patient privacy. 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. This notice applies to all of the records concerning your care generated by the practice, whether made by the practice or an associated facility or doctor. This notice describes our Practice's policies, which extend to any health care professional authorized to enter information into your chart; all areas of the Practice; all employees, staff and other personnel that work for or with our Practice; our business associates, on-call physicians ,and so on. The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

WE ARE REQUIRED BY LAW TO:

• Make sure that the protected health information about you is kept private;
• Provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
• Follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

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

MEDICAL 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 to you.

HEALTH CARE 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.

APPOINTMENT AND PATIENT RECALL REMINDERS - We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise which could (potentially) be received or intercepted by others.

EMERGENCY SITUATIONS - In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

FAMILY & FRIENDS - 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.

RESEARCH - We do not disclose any identifying medical information about you for research purposes without your signed authorization. If the information has been de-identified, an authorization for the use or disclosure is not required.

REQUIRED BY LAW - We will disclose medical information about you when required to do so by federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY - We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

ORGAN AND TISSUE DONATION - If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary.

PUBLIC HEALTH RISKS - Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following: To prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

INVESTIGATION AND GOVERNMENT ACTIVITIES - We may disclose medical information to a local, state or federal agency for activities authorized bylaw. These activities include, for example, audits, investigations, inspections, and licensure.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU (2)

LAWSUITS AND DISPUTES - If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order or a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

LAW ENFORCEMENT - We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process about a victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct at the Practice; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS - We may release medical information to a coroner, medical examiner or funeral director.

INMATES - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time and to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. Each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager (850-234-7080), who will direct you on how to file an office complaint. All complaints must be submitted in writing, and shall be investigated, without repercussion to you.

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization, unless those uses can be reasonably inferred from the intended uses above. You may revoke that authorization in writing, at anytime. You understand that we are unable to take back any disclosures we have already made with your permission.

PATIENT RIGHTS

RIGHT TO INSPECT AND COPY: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care may also be disclosed. To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. We may charge a fee for the costs of copying,

mailing or other supplies (tapes, disks, etc.) associated with your request. We may deny your request to inspect and copy in limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. We will comply with the outcome and recommendations from that review.

RIGHT TO AMEND: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others. To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclosure of your healthinformation. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: 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 the alternative means or location you request.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have a right to a paper copy of this notice at any time upon your request.