ADAM N.STILL, D.M.D
2389 RINGLING BLVD.
SARASOTA, FL 34237
(941) 957-3311
FAX: (941) 957-3310
www.SmileSarasota.com

Welcome

SMILE SARASOTA
Your Dental Care Specialists

ABOUT YOU

Today's Date:_____

First Name:_____

Last Name: _____

I prefer to be called:_____

Male Female SS#:_____

Title: Miss Ms. Mrs. Mr. Dr. Other_____

Address:_____

City:_____ **State:** _____

ZIP:_____ **Date of Birth:** _____/_____/_____

Single Married Divorced Widowed Separated

Home Phone: ( ) _____

Work Phone: ( ) _____

Cell Phone: ( ) _____

E-mail address:_____

How would you like appointments confirmed? (Circle all that apply):
Home Phone Work Phone Cellphone Text Message E-Mail

When and where are best times to reach you?

_____

Summer Address:

_____

City:_____**State:**_____**ZIP:** _____

Phone: ( ) _____

Employer: _____

Employer's Address:_____

_____

_____

Occupation:_____

If Retired, Previous Occupation:_____

_____

Whom may we thank for referring you?

_____

_____

Other family members seen by us:

_____

Previous / Present Dentist:

_____

_____

Last Dental Visit Date:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Employer: _____

Work #:_____ **Birthdate:**_____

Relationship:_____

Employer: _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE
Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #_____

Group # (Plan, Local or Policy #)_____

Insured's Name:_____**Relation:** _____

Insured's Employer:_____

Insured's Date of Birth: ____/____/____

Insured's ID# or SS#:_____

Employers Address:_____

_____

SECONDARY DENTAL INSURANCE
Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #_____

Group # (Plan, Local or Policy #)_____

Insured's Name:_____**Relation:** _____

Insured's Employer:_____

Insured's Date of Birth: ____/____/____

Insured's ID# or SS#:_____

Employers Address:_____

Continued

MEDICAL & DENTAL HISTORY

Because oral health is closely linked to overall health, an accurate and current medical history is an essential tool in providing quality dental care. It can alert us to specific concerns that may impact the delivery of your oral health care.

DENTAL HISTORY:

YOUR NAME:_____ **TODAY'S DATE**: _____/_____/_____

STREET:_____CITY:_____ST:_____ZIP_____

PHONE #:_____-_____-_____ CELL PH#: _____-_____-_____E-MAIL ADDRESS:_____

ARE YOU UNDER DENTAL CARE ELSEWHERE? (i.e. Summer Dentist / Periodontist / Orthodontist) YES ❑ NO ❑

IF SO, DENTIST'S NAME:_____ PHONE #:_____

STREET:_____CITY:_____ST:_____ZIP_____

HAVE YOU NOTICED:			**HAVE YOU HAD ANY OF THE FOLLOWING:**		
TIRED JAWS IN THE MORNING	YES ❑	NO ❑	ORTHODONTIC TREATMENT	YES ❑	NO ❑
NECK OR SHOULDER ACHES	YES ❑	NO ❑	PERIODONTAL (GUM) TREATMENT	YES ❑	NO ❑
MOUTH ODORS OR BAD TASTES	YES ❑	NO ❑	ORAL SURGERY	YES ❑	NO ❑
SORES OR LUMPS IN / NEAR YOUR MOUTH	YES ❑	NO ❑	A BITE PLATE OR MOUTH GUARD	YES ❑	NO ❑

HAVE YOUR PARENTS EXPERIENCED GUM DISEASE OR TOOTH LOSS? YES ❑ NO ❑
ARE YOU INTERESTED IN HAVING YOUR TEETH WHITENED? YES ❑ NO ❑
WOULD YOU LIKE TO RECEIVE OUR E-NEWSLETTER? YES ❑ NO ❑

MEDICAL HISTORY

MEDICAL HISTORY:

PHYSICIAN'S NAME:_____ PHONE NUMBER:_____-_____-_____

HAVE YOU BEEN HOSPITALIZED FOR SURGICAL CARE OR SERIOUS ILLNESS WITHIN THE LAST FIVE (5) YEARS? YES ❑ NO ❑

DO YOU REQUIRE **PRE-MEDICATION FOR DENTAL APPOINTMENTS?** YES ❑ NO ❑ If YES, name of Rx:_____
ARE YOU TAKING ASPIRIN OR A PRESCRIPTION **BLOOD THINNER** ? YES ❑ NO ❑
ARE YOU TAKING ANY **PRESCRIPTION MEDICATION(S) SUCH AS FOSAMAX FOR OSTEOPOROSIS?** YES ❑ NO ❑
ARE YOU TAKING ANY VITAMINS OR NON-PRESCRIPTION MEDICATION FOR OSTEOPOROSIS? YES ❑ NO ❑
NAME OF PHARMACY:_____PHONE #:_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (OR ATTACH LIST). PLEASE PROVIDE SPECIFIC DETAILS BELOW:

_____ _____
_____ _____
_____ _____
_____ _____

DO YOU USE TOBACCO? YES ❑ NO ❑ DO YOU USE EXTRA PILLOWS TO SLEEP? YES ❑ NO ❑
DO YOU USE CONTROLLED SUBSTANCES? YES ❑ NO ❑

ARE YOU AWARE OF HAVING HAD AN ADVERSE ALLERGIC REACTION TO ANY OF THE FOLLOWING?

LOCAL ANESTHETICS	YES ❑	NO ❑	SEDATIVES	YES ❑	NO ❑
IODINE	YES ❑	NO ❑	SULFA DRUGS	YES ❑	NO ❑
LATEX RUBBER	YES ❑	NO ❑	ASPIRIN	YES ❑	NO ❑
BARBITURATES	YES ❑	NO ❑	ANTIBIOTICS	YES ❑	NO ❑
METALS (NICKEL, MERCURY, ETC.)	YES ❑	NO ❑	PRESCRIPTION PAIN MEDICATION	YES ❑	NO ❑
ACRYLIC	YES ❑	NO ❑			

IF YES TO ALLERGY TO ANTIBIOTICS, PAIN MEDICATIONS OR OTHER ALLERGIES NOT LISTED ABOVE, PLEASE PROVIDE DETAILS BELOW:

_____
_____
_____

Continued on reverse side ⟶

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

ANEMIA	YES ❑ NO ❑	HEPATITIS/JAUNDICE	YES ❑ NO ❑
ANGINA	YES ❑ NO ❑	HERPES/COLD SORES	YES ❑ NO ❑
ARTIFICIAL HEART VALVE	YES ❑ NO ❑	HIGH BLOOD PRESSURE	YES ❑ NO ❑
ARTIFICIAL JOINTS / JOINT REPLACEMENT	YES ❑ NO ❑	HIV / AIDS	YES ❑ NO ❑
ASTHMA / BRONCHITIS	YES ❑ NO ❑	KIDNEY DISEASE	YES ❑ NO ❑
ATRIAL FIBRILLATION	YES ❑ NO ❑	LEUKEMIA	YES ❑ NO ❑
BLOOD DISORDER OR EXCESSIVE BLEEDING	YES ❑ NO ❑	LIVER DISEASE	YES ❑ NO ❑
BONE INFECTION / DISORDERS	YES ❑ NO ❑	LOW BLOOD PRESSURE	YES ❑ NO ❑
CANCER	YES ❑ NO ❑	MITRAL VALVE PROLAPSE	YES ❑ NO ❑
CHEMOTHERAPY	YES ❑ NO ❑	OSTEOPOROSIS	YES ❑ NO ❑
CHEST PAIN / EASILY WINDED	YES ❑ NO ❑	PACEMAKER	YES ❑ NO ❑
DEMENTIA	YES ❑ NO ❑	PARKINSON'S DISEASE	YES ❑ NO ❑
DIABETES	YES ❑ NO ❑	RADIATION TREATMENT	YES ❑ NO ❑
EMOTIONAL DISTURBANCE / DEPRESSION	YES ❑ NO ❑	RESPIRATORY PROBLEMS	YES ❑ NO ❑
EMPHYSEMA	YES ❑ NO ❑	RHEUMATIC FEVER	YES ❑ NO ❑
EPILEPSY / SEIZURES / CONVULSIONS	YES ❑ NO ❑	SEXUALLY TRANSMITTED DISEASE	YES ❑ NO ❑
FAINTING / DIZZINESS	YES ❑ NO ❑	SINUS ISSUES	YES ❑ NO ❑
GLAUCOMA	YES ❑ NO ❑	STOMACH PROBLEMS / ULCERS / ACID REFLUX	YES ❑ NO ❑
HAY FEVER / ALLERGIES	YES ❑ NO ❑	STROKE	YES ❑ NO ❑
HEARING DIFFICULTY	YES ❑ NO ❑	THYROID DISEASE	YES ❑ NO ❑
HEART DISEASE / HEART ATTACK	YES ❑ NO ❑	TUBERCULOSIS	YES ❑ NO ❑
HEART MURMUR	YES ❑ NO ❑		

OTHER CONDITIONS NOT LISTED ABOVE: _____

WOMEN ONLY:

ARE YOU TAKING ORAL CONTRACEPTIVES?	YES ❑ NO ❑	HAVE YOU ENTERED MENOPAUSE?	YES ❑ NO ❑
ARE YOU PREGNANT?	YES ❑ NO ❑	DO YOU TAKE ESTROGEN?	YES ❑ NO ❑
ARE YOU NURSING?	YES ❑ NO ❑	IF SO, WHAT TYPE?	_____

AUTHORIZATION / RELEASE:

AS A CONDITION OF YOUR TREATMENT BY THIS OFFICE, FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE. THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM THE PATIENTS FOR THE COSTS INCURRED IN THEIR CARE AND FINANCIAL RESPONSIBILITY ON THE PART OF EACH PATIENT MUST BE DETERMINED BEFORE TREATMENT. ALL EMERGENCY DENTAL SERVICES, OR ANY DENTAL SERVICES PERFORMED WITHOUT PREVIOUS FINANCIAL ARRANGEMENTS, MUST BE PAID FOR AT THE TIME SERVICES ARE PERFORMED. PATIENTS WHO CARRY DENTAL INSURANCE UNDERSTAND THAT ALL DENTAL SERVICES ARE, AS A COURTESY, SUBMITTED TO YOUR INSURANCE. THIS DENTAL OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY AN INSURANCE COMPANY. I UNDERSTAND THAT THE FEE ESTIMATE LISTED FOR THIS DENTAL CARE CAN ONLY BE EXTENDED FOR A PERIOD OF 30-DAYS FROM THE DATE OF THE PATIENT EXAMINATION. IN CONSIDERATION FOR THE PROFESSIONAL SERVICES RENDERED TO ME, OR AT MY REQUEST, BY THE DOCTOR, I AGREE TO PAY THE REASONABLE VALUE OF SERVICES TO THE DOCTOR, OR HIS ASSIGNEE, AT THE TIME SERVICES ARE RENDERED. APPOINTMENTS CHANGED OR RESCHEDULED ON SHORT NOTICE MAY BE SUBJECT TO A MISSED APPOINTMENT FEE. I FURTHER AGREE TO THE FOLLOWING: THAT THE REASONABLE VALUE OF SERVICES SHALL BE PAID UNLESS OBJECTED TO, BY ME, IN WRITING. I WILL NOT HOLD SMILE SARASOTA, MY DENTIST OR ANY MEMBER OF THE STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS IN COMPLETING THIS FORM. I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

_____ _____/_____/_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE** **RELATIONSHIP TO PATIENT**

_____ ____/____/____

SIGNATURE OF GUARANTOR OR PAYMENT/RESPONSIBLE PARTY **DATE**

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help!

OFFICE USE ONLY:

_____

_____

Adam N. Still, D.M.D., P.L.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 8, 2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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 Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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 information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Privacy Official: Jaime Still Telephone: 941-957-3311 Fax: 941-957-3310
Address: 2389 Ringling Blvd., Ste C., Sarasota, FL 34237 E-Mail: info@smilesarasota.com

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Adam N. Still, D.M.D., P.L.

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices document our good faith effort to obtain that acknowledgment.

You May Refuse to Sign This Acknowledgment

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

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

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

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

_____

_____

_____

PATIENT DENTAL INSURANCE WAIVER

I have requested dental services provided by Adam Still, D.M.D., P.L.
I understand that services will be billed by Adam Still D.M.D., P.L. to my dental insurance company. I further understand I am responsible for all charges incurred today and that payment is due at the time of service.
Adam Still D.M.D., P.L. is not an in-network provider with my dental insurance. The scope of services rendered by Adam Still D.M.D., P.L. may or may not be covered by my dental insurance policy. In addition, if services are covered by my dental insurance provider, they may not be covered in full.

Patient Signature (or parent/guardian/other-authorized person if patient is a minor, mentally incompetent, or physically unable to sign this form)
_____

Date _____

Printed Name and Relationship of Person Authorized to Sign for Patient
_____
_____