Patient Name: (NOMBRE) _____ **Date(*FECHA*)**_____
Last, First MI (Preferred Name)

Guardian (NOMBRE DE PADRE/MADRE)_____ **Sex (SEXO) F M**

Marital Status (ESTADO CIVIL) M__S__ D__ **Social Security # *(SEGURO SOCIAL):*** _____

Birth Date: (FECHA DE NACIMIENTO)_____ **Cell** _____ **Work Phone (trabajo)**_____

Address: (DIRECCION) _____
Street Apartment #

City _____ **State** _____ **Zip Code**_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE (QUIEN LO REFIRIO A LA OFICINA) _____

****** E-MAIL** _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV -SIDA
☐ Allergies-Alergias
☐ Anemia - Anemia
☐ Arthritis- Artritis
☐ Artificial Joint- Protesis
☐ Asthma- Asma
☐ Blood Disease-Enfermedad en la sangre
☐ Cancer
☐ Diabetes- Diabetis Type?
☐ Dizziness- Mareos
☐ Epilepsy- Epilepsia
☐ Excessive Bleeding-Sangramiento excesivo
☐ Fainting-Desmayos
☐ Glaucoma
☐ Growths-Tumores
☐ Head Injuries-Lesiones en la cabeza
☐ Heart Disease-Problemas del corazon
☐ Heart Murmur – Soplo en el Corazon
☐ Hepatitis
☐ High Blood Pressure-Presion alta
☐ Jaundice-
☐ Kidney Disease-Enfermedades Renales
☐ Liver Disease-Enfermedad del Higado
☐ Mental Disorders-Trastornos Mentales
☐ Nervous Disorders-Trastornos Nerviosos
☐ Pacemake-Marcapasos
☐ Are you Pregnant ? Esta Embarazada ? Due date:_____
☐ Radiation Treatment-Radiaciones
☐ Respiratory Problems-Problemas Respiratorios
☐ Rheumatic Fever-Fiebre Reumatica
☐ Rheumatism-Reumatismo
☐ Sinus Problems-Problemas Nasales
☐ Stomach Problems-Problemas Estomacales
☐ Stroke- Infartos
☐ Tuberculosis
☐ Ulcers- Ulceras
☐ Venereal Disease-Enfermedades Venereas
☐ Codeine Allergy-Alergia a la **Codeina**
☐ Penicillin Allergy-Alergia a la **Penicilina**
OTHER:
☐ _____
☐ _____

• Have you ever had any complications following dental treatment? ¿Ha tenido usted alguna complicacion depues de un tratamiento dental?
☐ Yes/Si ☐ No?No
If yes, please explain: Si es Si, explique cual: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? ¿Ha estado hospitalizado, ha tenido alguna enfermedad grave o lo han operado en los ultimos dos años? ☐ Yes/ Si ☐ No/No
If yes, please explain: Si es Si, explique : _____

• Are you now under the care of a physician? ¿Esta bajo algun cuidado medico? ☐ Yes/SI ☐ No/No
If yes, please explain: _____

• Name of Physician: Nombre del medico _____ Phone: _____

• Do you have any health problems that need further clarification? ¿Tiene usted alguna condicion medica que necesite aclarar ☐ Yes/SI ☐ No/NO
If yes, please explain:Si es SI, explique _____

•Are you taking any medications ? ¿Esta tomando algun medicamento? ? ☐ Yes/SI ☐ No/No
If yes, please list: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail
.En mi conocimiento toda la informacion y respuestas anteriormente proporcionadas, son verdaderas y correctas. Si hay algun cambio en mi salud le comunicare de inmediato al medico.

_____ Date: _____
Signature of patient, parent or guardian Firma del paciente o el guardian

Palmetto Smile Center

6500 Cowpen Rd Suite 104
Miami Lakes, Fl 33014

Insurance Non Payment Consent

As Patient or Legal Guardian of patient, I agree to pay for ALL services rendered within 60 days of services in accordance with the Financial Policy of this office. In the event Legal action should become necessary, I agreed to be responsible for and pay all reasonable attorneys and court fees incurred. I understand that this office bills the insurance as a COURTESY and that the payment of charges for these services is my responsibility.

Patient Name

Signature

Date

Patient **Photo Release** Form I _____, hereby authorize Palmetto Smile Center, or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, instagram posts, etc). I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing. If declining this consent, leave blank.

Please initial one option:
_____I do not mind if my photographs are used in any of the above stated situations.
_____I only agree to have my teeth shown without any identifying features.

Signed_____Date_____

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Miami Lakes, Fl 33014

What is the HIPAA Privacy Rule?

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. It is a federal law under which the Secretary of the U.S. Health and Human Services issue regulations that give patients protections over the privacy of their dental records.

The final privacy regulation took effect April 14, 2003. It balances strong privacy protections against efficiency and access to qualify health care. Patients are guaranteed access to their dental records; given more control over their protected health information is used and disclosed; and are allowed to file complaints if their medical privacy is breached. The privacy rule protects medical records and other personal health information maintained by certain dentist, physicians, hospitals, health plans, health insurances and health-care clearinghouses.

Under the privacy rule, this dental practice:

- Must get your specific authorization before we may use or disclose your protected information in non-routine circumstances, such as releasing information to an employer or for use in marketing activities.
- Will allow you to request an account of non-routine uses and disclosure of your health information.
- Will provide you with written notice of our privacy practices and your privacy rights. Patient will generally be ask to sign, or otherwise acknowledge receipts of, the privacy notice from direct treatment providers such as dentists.
- May communicate freely with you about treatment options and with other health-care providers involved in your care.
- Will allow you access to access your personal dental records and request changes to correct any errors.

The privacy rule, established as part of the federal privacy act, enhances protections under existing Florida Law. Our dental practice adheres to Florida Laws and federal laws that protect your health information. Our policies apply to all patients in this dental practice, whether they are private insured, uninsured or covered under public programs such as Medicare or Medicaid.

We care about your oral health and are here to help you. If you have any questions about how the HIPAA privacy regulation relates to your dental care, please feel free to contact our office.

Print Name:_____

Signature_____

Date:_____

Palmetto Smile Center

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Cancellation Policy

To our valued Patients,
We at Palmetto Smile appreciate your business.
Please be on time for your appointment and notify us 24 hours in advance if you need to cancel or reschedule your appointment.
Same day cancellations will be charged a $25 cancellation fee.
Payments made to Palmetto Smile will not be refunded, but may be issued in treatment credit in some cases at the discretion of Palmetto Smile.

Date: _____

Signature: _____

PREFERENCE OF PHARMACY:

Pharmacy Name:_____

Address:_____

Phone Number:_____