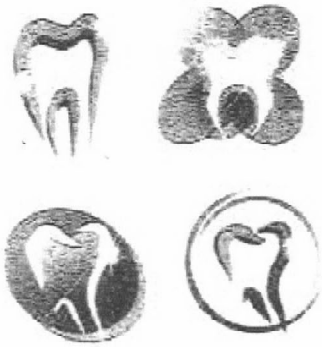

Nawrocki Dental
Gary C. Nawrocki, DMD
4301 N. Banana River Blvd
Cocoa Beach, Fl. 32931
(321)783-7514
www.Cocoabeachdentist.com
Email: Info@cocoabeachdentist.com

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET APT #

_____
CITY STATE ZIP

Employer _____ Driver License _____

Birth Date _____ ☐ Married ☐ Single ☐ Other

Height _____ Weight _____ ☐ Male ☐ Female

Phone: Home (_____)_____ Social Security # _____
Work (_____)_____
Cell (_____)_____ Email _____

Emergency Contact: Name_____ Phone (_____)_____

How did you hear about us? ☐ Yellow Pages ☐ Google ☐ Yahoo ☐ DexKnows ☐ Walk in/Drive by ☐ Insurance ☐ Mailer
☐ Referred By: _____ ☐ Other_____

Insurance

Primary Dental Carrier

Insurance Co Name: _____ Phone #: _____
Insured's Name: _____ Birth Date: _____ ID#: _____
Insured's Employer: _____ Group #: _____
Relationship to Patient: _____

Secondary Dental Carrier

Insurance Co Name: _____ Phone #: _____
Insured's Name: _____ Birth Date: _____ ID#: _____
Insured's Employer: _____ Group #: _____
Relationship to Patient: _____

If Patient Is Under 18 Years Of Age

Responsible Party _____ Relation to Patient _____

Address _____
STREET CITY STATE ZIP

The information on this page is correct to the best of my knowledge

_____ _____
PATIENT OR PARENT/GUARDIAN SIGNATURE DATE

_____
PATIENT OR PARENT/GUARDIAN SIGNATURE

Other Information

Physician's Name_____ Physician's Phone _____

Have you had a serious illness or operation? Y ☐ N ☐

If yes, please describe_____

Are you currently under physician care? Y ☐ N ☐

If yes, please describe_____

Medical History and Information: *Please check those conditions that have ever applied to you*

Conditions

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ **Artificial Heart Valve**
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ **Congenital Heart Defect**
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Facial Surgery
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV+ Aids
- ☐ **Heart Attack**
- ☐ **Joint Replacement**
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ **Rheumatic Fever**
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin

Other Allergies:

_____

_____

Y	N	
☐	☐	Do you Smoke or use Tobacco?

Women Only

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	**Are you pregnant? If yes, # of weeks** _____
☐	☐	Are you nursing?

Please list any medications you are currently taking:

_____

_____

Have you EVER taken any bisphosphonates? (e.g. Fosomax, Actonel) Y ☐ N ☐

Treatment Authorization

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

_____ _____

PATIENT OR PARENT/GUARDIAN **PRINT NAME** DATE

_____

PATIENT OR PARENT/GUARDIAN **SIGNATURE**

Cancelation Policy

Due to the high number in patients requiring dental care, waiting times for appointments can be long. Because of this, we have updated our cancelation policy to ensure other patients receive care in a timely manner. You **MUST** cancel your appointment **AT LEAST** 48 hours ahead of your set appointment time. Appointments missed or canceled within less than 48 hours ahead of time will cost you $100 per scheduled hour with the doctor or $50 per scheduled hour with a hygienist.

Signature_____ Date_____

Office Financial Policy

Payment is expected at time of service. We will accept cash, check, or credit card. Checks are accepted with valid driver's license only. There will be a $25 service charge for a returned check.

Gary C Nawrocki, D.M.D, M.A.G.D, D.I.C.O.I, is pleased to offer an in-office dental benefit program for our patients to receive optimal dental care while maintaining their oral health.

Past due accounts may be turned over to a collection agency. Any fees incurred due to this, will be added to the outstanding balance. This may include late fees, collection agency fees, court fees etc.

Signature:_____ Date:_____

Dental Insurance Policy

We will file for insurance companies, however it is completely the patient's responsibility to give us their insurance information.

If any payment from an insurance company becomes 30 days past due, you will be billed immediately for the entire balance.

We will file pre-treatment estimates, **AT YOUR REQUEST ONLY**. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. In all cases it may delay dental care.

Not all services are covered by insurance. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Our staff can never guarantee your eligibility and coverage.

Insurance limitations and regulations vary with all insurance plans. Therefore, if your insurance plan denies a service, you will be responsible for the complete charge. We do not base your treatment plan on what your insurance plan covers or doesn't cover. We are working for you, not the insurance company.

Signature:_____ Date:_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ on this date _____ / _____ / _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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RECEIVE APPOINTMENT REMINDERS VIA EMAIL AND TEXT!!

PLEASE CHECK A SOURCE IN WHICH YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS

- ☐ Email
- ☐ Text Message
- ☐ Both Email and Text Message

*Email Address:*_____
(if applicable)

*Cell Phone:*_____
(if applicable) **MUST REPLY WITH "Y" WHEN PROMPTED**

Please sign below that you agree to allow us to use this information in providing your services.

Print Name_____

Signature_____ Date _____