



# DENTAL & MEDICAL SPA WINDERMERE

## Welcome to Our Office!

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

### Patient Information (Confidential)

Name \_\_\_\_\_ Date \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Expiration date \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

When confirming appointments how do you prefer to be contacted? Phone Email Text Message

Approval to leave a message?  No  Yes

### How did you hear about our office? (Check All That Apply)

Mail Google Website Yellow Pages Drive By Brochure Friend or Patient \_\_\_\_\_

### Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security# \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Patient Medical History

Primary Care Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

1. Are you under medical treatment now? NO/YES, please explain \_\_\_\_\_

2. Have you ever been hospitalized for any surgical operations (including plastic surgery) or serious illnesses within the last 5 years? NO/YES, please explain \_\_\_\_\_

3. Are you taking any medication(s) including non-prescription medicine? NO/YES, if so please list what medications are you taking? \_\_\_\_\_

4. Do you use Tobacco? NO/YES      6. Do you use controlled substances or recreational drugs? NO/YES

5. Are You **Allergic** to any medications? NO/YES, please explain \_\_\_\_\_



# DENTAL & MEDICAL SPA WINDERMERE

6. Have you ever had a reaction to any of the following?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Local anesthetics              | <input type="checkbox"/> Aspirin, Acetaminophen, or Ibuprofen | <input type="checkbox"/> Reaction to metals |
| <input type="checkbox"/> Antibiotics                    | <input type="checkbox"/> Codeine, Demerol, or other narcotics | <input type="checkbox"/> Latex or Rubber    |
| <input type="checkbox"/> Sulfa drugs                    |   | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Barbiturates or sleeping pills |   | _____                                       |

7. Do you have, or have you had any of the following? (Please check all that apply)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Heart problems          | <input type="checkbox"/> Intestinal Problems                              | <input type="checkbox"/> Persistent cough or swollen glands     | <input type="checkbox"/> Psychological treatment   |
| <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Ulcers   | <input type="checkbox"/> Cancer/ Tumor                          | <input type="checkbox"/> Vitiligo                  |
| <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Weight gain/loss                                 | <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Auto-immune disease       |
| <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Constipation/ Diarrhea                           | <input type="checkbox"/> Tuberculosis                           | <input type="checkbox"/> Skin diseases/skin cancer |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Kidney or bladder problems                       | <input type="checkbox"/> Hepatitis, jaundice, or liver trouble  | _____ (type)                                       |
| <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Herpes virus                           | <input type="checkbox"/> Keloid scarring           |
| <input type="checkbox"/> Artificial heart valve  | <input type="checkbox"/> Back or neck pain                                | <input type="checkbox"/> STD _____                              | <input type="checkbox"/> Alcoholism                |
| <input type="checkbox"/> Bruises easily          | <input type="checkbox"/> Any active infection                             | <input type="checkbox"/> HIV-positive/ AIDS                     | <input type="checkbox"/> MRSA                      |
| <input type="checkbox"/> Frequent nosebleeds     | <input type="checkbox"/> Joint replacement _____ <input type="checkbox"/> | <input type="checkbox"/> Glaucoma                               | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Anemia                  | Fainting, seizures or epilepsy  | <input type="checkbox"/> Seizure disorder                       |  |
| <input type="checkbox"/> Allergy problems        | <input type="checkbox"/> Stroke   | <input type="checkbox"/> History of head injury                 |  |
| <input type="checkbox"/> Hormone imbalance       | <input type="checkbox"/> Headaches/ Migraines                             | <input type="checkbox"/> Epilepsy or other neurological disease |  |
| <input type="checkbox"/> Sinus problems          | <input type="checkbox"/> Thyroid problems                                 |   |  |
| <input type="checkbox"/> Skin rashes             |   |   |  |
| <input type="checkbox"/> Asthma                  |   |   |  |

**Women Only:**



# DENTAL & MEDICAL SPA WINDERMERE

a) Are you pregnant? NO/YES, \_\_\_\_\_ weeks

c) Are you Nursing? NO/YES

b) Are you taking contraceptives or hormones?  
NO/YES, \_\_\_\_\_

d) Have you reached Menopause? NO/YES, if so are  
you having symptoms? \_\_\_\_\_

## Dental History

Previous Dentist \_\_\_\_\_

Date of Last Exam/Cleaning \_\_\_\_\_

1. Are you apprehensive about dental treatments or  
procedures? No  Yes

10. Are you dissatisfied with the appearance of your  
teeth? No  Yes

2. Have you had problems with previous dental  
treatments? No  Yes

11. How often do you brush? \_\_\_\_\_

3. Does food catch between your teeth? No  Yes

12. How often do you floss? \_\_\_\_\_

4. Do you have difficulty chewing your food?  
No  Yes

13. Do you clench or grind your teeth frequently? No   
Yes

5. Do you chew on only one side of your mouth? No   
Yes

14. Do your jaws ever feel tired? No  Yes

6. Do your gums bleed easily? No  Yes

15. Does your jaw get stuck closed? No  Yes

7. Do your gums bleed when you floss? No  Yes

16. Do you have earaches or pain in front of ears?  
No  Yes

8. Are your teeth sensitive? No  Yes

17. Do you have a temporomandibular (jaw) disorder  
(TMD)? No  Yes

9. Do you feel discomfort when your teeth encounter  
hot/cold? No  Yes

18. Do you require medication before dental  
procedures? No  Yes

## Aesthetic History

Have you ever had  Botox,  fillers, or  facial lasers? If so, when? \_\_\_\_\_

1. Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?  No  Yes, describe: \_\_\_\_\_

2. How often are you exposed to the sun or use a tanning bed? \_\_ Infrequently \_\_ Frequently  
\_\_ Regularly

3. What SPF do you use on your face? \_\_\_\_\_ How often? \_\_\_\_\_

4. What skin care products are you currently using? \_\_\_\_\_



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**WINDERMERE**

5. Have you been treated with Accutane?  No  Yes, last treatment \_\_\_\_\_

I would like to know more about (please check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Microblading            | <input type="checkbox"/> BOTOX®/Dysport Cosmetic for wrinkles |
| <input type="checkbox"/> Facial Fillers          | <input type="checkbox"/> Skin care products/advice            |
| <input type="checkbox"/> PRP                     | <input type="checkbox"/> Jaw reduction                        |
| <input type="checkbox"/> Facial redness          | <input type="checkbox"/> Stretch mark therapy                 |
| <input type="checkbox"/> Acne injections         | <input type="checkbox"/> Spider vein therapy                  |
| <input type="checkbox"/> Chemical Peels          | <input type="checkbox"/> Nonsurgical Rhinoplasty              |
| <input type="checkbox"/> Chin augmentation       | <input type="checkbox"/> Hand rejuvenation                    |
| <input type="checkbox"/> Chest/Neck rejuvenation | <input type="checkbox"/> TMJ/Grind jaw therapy                |
| <input type="checkbox"/> “Gummy Smile” treatment | <input type="checkbox"/> Scar treatment                       |
| <input type="checkbox"/> Earlobe enhancement     | <input type="checkbox"/> Sculptra butt lift                   |
| <input type="checkbox"/> Brow lift               | <input type="checkbox"/> Sculptra cellulite                   |
| <input type="checkbox"/> Microneedling           | <input type="checkbox"/> Kybella                              |
| <input type="checkbox"/> Oily Skin               | <input type="checkbox"/> _____                                |

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Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all service rendered on behalf of myself and/or on the behalf of my dependents.

Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ Relationship \_\_\_\_\_



# DENTAL & MEDICAL SPA WINDERMERE

## CONSENT TO SHARE PROTECTED HEALTH INFORMATION

### **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 of Privacy Practices describes how we may use and disclose your protected health/personal information (PHI) to carry out treatment, payment or business operations (TPO) and for other purposes that are or required by law. It also describes our rights to access and control your protected information. Protected health/personal information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

#### **1. Uses and Disclosures of Protected Health/Personal Information**

##### Uses and Disclosures of Protected Health/Personal Information

Your protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to support business operations of this office, if requested to you by a finance company to pay for your care, and any other use required by law.

**Treatment:** We will use and disclose your protected health/personal information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health/personal information, as necessary, if, as a result of our services, you require treatment by a physician. Your protected health/personal information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

**Payment:** Your protected health/personal information will be used, if requested, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval.

**Healthcare Operations:** we may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health/personal information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law, communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; inmates; required uses and disclosures. Under the law, we must make disclosure to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

**Other permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

#### **2. Your Rights**

Following is a statement of your rights with respect to your protected health/personal information.

**You have the right to inspect and copy your protected health/personal information.** Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected health/personal information.

**You have the right to require a restriction of your protected health/personal information.** This means you may ask us not to use or disclose any part of your health/personal information for the purposes of treatment or healthcare operations. You may also request that any part of your protected health/personal information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree a restriction that you may request. If our medical director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your protected health/personal information will not be restricted. You then have the right to use another service provider.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

**You may have the right to amend your protected health/personal information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal.



# DENTAL & MEDICAL SPA WINDERMERE

**You have the right to receive an accounting of certain disclosures we have made, of any, of your protected health/personal information.**

We reserve the right to change this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **September 14, 2017.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health/personal information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

**Consent to Share Protected Health Information**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. To comply with HIPAA regulations, we must obtain your permission to share your protected health information with any other patients with comprehensive care, and as such, we request your consent to disclose your protected health information to Windermere Dental for the purposes of providing certain services, treatment, for billing purposes, and for healthcare operations.

You understand and agree to the following:

- Your protected health information may be disclosed to or used by Windermere Dental and Windermere Medical Spa for services, treatment, billing, or healthcare operations.
- Your protected health information will not be disclosed to any other entity or person unless we are specifically authorized to do so under the law or by written statement from you.
- We may condition receipt of treatment upon the execution of this consent.
- You have the right to receive a copy of this consent.
- Windermere Dental and Windermere Medical Spa will not further use or disclose the medical information to any other person unless you specifically request the disclosure, or the disclosure is required or permitted by law.
- This Consent to share your information shall be valid for one year from the date of this Consent.
- You may revoke this Consent in writing at any time and all future disclosures to Windermere dental and Windermere Medical Spa will then cease. However, such a revocation shall not affect and disclosures we have already made in reliance on your prior Consent.
- You understand that if you choose to revoke your consent, you will still be able to receive any services or treatments that you have already paid for or are in the process of receiving, as long as this information is not needed to provide those services or treatments.

By signing this form, you acknowledge and certify that you have read and understand the “consent, release and indemnity agreement,” you also voluntarily consent to our use and disclosure of your protected health information to Windermere Dental and Windermere Medical Spa in the manner, term, and purposes identified above.

Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ Relationship \_\_\_\_\_



**DENTAL & MEDICAL SPA**  
**WINDERMERE**

**Radiographic Consent**

I, \_\_\_\_\_, consent to be a patient at the above-named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During my treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with doses, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
5. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ Relationship \_\_\_\_\_



**DENTAL & MEDICAL SPA**  
**WINDERMERE**

**Financial Policy**

- As a patient of Windermere Dental & Medical Spa, you understand that you are responsible to pay for services and treatment provided by our office. We require that you pay your portion on the day services are rendered. If you would like to put your balance on your credit or debit card, we accept the following: VISA, MasterCard, Discover & American Express. We are happy to offer a flexible financing option through: Care Credit. For uninsured patients we offer our Dental Savings Plan.
- You also understand that even if an estimate is given or a procedure has been pre-approved you are responsible for any costs that your insurance company does not cover.
- To accommodate our patient's time and busy schedule, we schedule exclusive appointments for each patient and always strive to stay on time. We sincerely ask that our patients respect this policy and provide us with at least 48 hours' notice if you are unable to keep the time we have reserved for your dental care. Appointments broken with less than 48 hours' notice will be charge a cancellation fee of \$50.

*By signing below, I agree that I am fully responsible for the total payment of all procedures performed in this office. I understand that my portion for services is due in full at the time of service unless other financial arrangements have been signed. Any portions billed to my insurance are to be paid in full within 90 days from the date of service, regardless of whether or not my insurance has provided reimbursement or allow the submitted charges. Any balance not paid in full within 90 days will accumulate a charge of 10% per month and I will be responsible for my balance, all finance fees, all collection agency fees, and any additional costs associated with collecting the full balance on my account.*

Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ Relationship \_\_\_\_\_





**DENTAL & MEDICAL SPA**  
**WINDERMERE**

**Insurance Policy**

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you.

Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay. Should your coverage be less than anticipated, you will be responsible for the difference.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. Better terms for dental insurance may be "dental assistance" or "dental benefits."

***Please remember, however, the financial obligation for dental treatment is between you and this office and is not between this office and your insurance company.***

I have read and understand the above and understand it is my responsibility to inform the office of any changes in my coverage.

Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ Relationship \_\_\_\_\_