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 _____

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

❑Local anesthetics
❑Antibiotics
❑Sulfa drugs
❑Barbiturates or sleeping pills
❑Aspirin, Acetaminophen, or Ibuprofen
❑Codeine, Demerol, or other narcotics
❑Reaction to metals
❑Latex or Rubber
❑Other_____
_____

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

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

Women Only:

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a) Are you pregnant? NO/YES, _____weeks

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

c) Are you Nursing? 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 ❑
2. Have you had problems with previous dental treatments? No❑Yes ❑
3. Does food catch between your teeth? No❑Yes ❑
4. Do you have difficulty chewing your food? No❑Yes ❑
5. Do you chew on only one side of your mouth? No❑ Yes ❑
6. Do your gums bleed easily? No❑Yes ❑
7. Do your gums bleed when you floss? No❑Yes ❑
8. Are your teeth sensitive? No❑Yes ❑
9. Do you feel discomfort when your teeth encounter hot/cold? No❑Yes ❑
10. Are you dissatisfied with the appearance of your teeth? No❑Yes ❑
11. How often do you brush? _____
12. How often do you floss? _____
13. Do you clench or grind your teeth frequently? No❑ Yes ❑
14. Do your jaws ever feel tired? No❑Yes ❑
15. Does your jaw get stuck closed? No❑Yes ❑
16. Do you have earaches or pain in front of ears? No❑Yes ❑
17. Do you have a temporomandibular (jaw) disorder (TMD)? 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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5. Have you been treated with Accutane? □ No □ Yes, last treatment _____

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

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

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 _____

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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 INFORMTION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health/personal information (PHI) to carryout 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 reacted 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 or 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 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 ant 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.

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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 without HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Consent to Share Protected Health Information

The Heath Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. To comply with HIPPA 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 discoveries 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 _____