PATIENT INFORMATION

LEGAL NAME (LAST) (FIRST) (M.INITIAL)	SEX	AGE	DATE OF BIRTH	SOCIAL SECURITY #

ADDRESS (#) (APT#)	(CITY) (STATE) (ZIP)

HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	DRIVERS LICENSE #

PERSON TO CONTACT IN CASE OF EMERGENCY:	EMERGENCY #	STUDENT Y N ☐ FULL TIME ☐ PART TIME

PREFERRED METHOD OF CONFIRMING YOUR APPOINTMENTS WITH OUR OFFICE: CALL OR TEXT
(PLEASE CIRCLE ONE)

COMPLETE THIS SECTION IF PATIENT IS A MINOR

PARENT OR LEGAL GUARDIAN NAME	DATE OF BIRTH	SOCIAL SECURITY #	DRIVERS LICENSE#

ADDRESS (COMPLETE ONLY IF DIFFERENT FROM CHILD'S ADDRESS	(CITY)	(STATE)	(ZIP)

HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	RELATIONSHIP TO PATIENT

PRIMARY DENTAL COVERAGE

SUBSCRIBER (LAST) (FIRST) (M.INITIAL)	DATE OF BIRTH	RELATIONSHIP TO PATIENT

EMPLOYER NAME	INSURANCE COMPANY	GROUP#	SOCIAL SECURITY#/MEMBER ID #

INSURANCE CO. TELEPHONE #	INSURANCE COMPANY MAILING ADDRESS

SECONDARY DENTAL COVERAGE

SUBSCRIBER (LAST) (FIRST) (M.INITIAL)	DATE OF BIRTH	RELATIONSHIP TO PATIENT

EMPLOYER NAME	INSURANCE COMPANY	GROUP#	SOCIAL SECURITY#/MEMBER ID #

INSURANCE CO. TELEPHONE #	INSURANCE COMPANY MAILING ADDRESS

ASSINGMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND AUTHORIZATION FOR TREATMENT

- I AUTHORIZE OTHER HEALTHCARE PROVIDERS TO RELEASE PERTINENT MEDICAL/DENTAL INFORMATION TO DR. SCOTT YORKO
- I AUTHORIZE THE RELEASE OF PERTINENT MEDICAL/DENTAL INFORMATION TO MY REFERRING DOCTORS
- I AUTHORIZE THE RELEASE OF PERTINENT MEDICAL/DENTAL INFORMATION TO INSURANCE CARRIERS
- I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE, INCLUDING ANY COLLECTION FEES, WHICH MAY BE UP TO AN ADDITIONAL 40%
- I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR

X _____ X _____

PATIENT SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR) DATE

MEDICAL/HEALTH QUESTIONAIRE

PATIENT NAME:_____ **DOB:** _____ **SEX: M F DATE:**_____

Email address:_____ **Social Security Number:** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES OR TREATMENTS? (PLEASE CHECK ALL THAT APPLY)

- ☐ AIDS
- ☐ ALCOHOL ABUSE
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINTS
- ☐ ARTIFICIAL VALVES
- ☐ ASTHMA
- ☐ BLOOD TRANSFUSION
- ☐ CANCER
- ☐ CHEMOTHERAPY
- ☐ COLITIS
- ☐ CONGENITAL HEART DEFECT
- ☐ COPD
- ☐ DIABETES
- ☐ DIFFICULTY BREATHING
- ☐ DRUG ABUSE
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ FAINTING SPELLS
- ☐ FEVER BLISTERS
- ☐ GLAUCOMA
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMER
- ☐ HEART SURGERY
- ☐ HEMOPHELIA
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV+
- ☐ IMPLANTS OF ANY KIND (HEART VALVE, HIP, KNEE, ETC.)
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ MITRAL VALVE PROLAPSE
- ☐ PACE MAKER
- ☐ PSYCHIATRIC PROBLEMS
- ☐ RADIATION TREATMENT
- ☐ SEVERE FREQUENT HEADACHES
- ☐ SHINGLES
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS (TB)
- ☐ ULCERS
- ☐ VENEREAL DISEASE

PRIMARY CARE PHYSICIAN NAME:_____ **PHONE:**_____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS?: IF YES PLEASE LIST:

_____

_____

_____

ARE YOU CURRENTLY TAKING ANY OVER THE COUNTER MEDICATIONS?: IF YES PLEASE LIST:

_____

_____

DO YOU HAVE AN ALLERGY TO LATEX? _____

PLEASE LIST ANY MEDICATIONS YOU ARE OR MAY BE ALLERGIC TO:

_____

FOR WOMEN ONLY:

ARE YOU PREGNANT? YES NO

ARE YOU NURSING? YES NO

ARE YOU TAKING BIRTH CONTROL : YES NO - If "YES" please indicate type : _____

DR. COMMENTS:

_____

PATIENT SIGNATURE: _____ **DATE:**_____

PATIENT NAME: _____ DOB: _____

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE

I understand that it is my responsibility to provide Weaver Family Dentistry with my current dental insurance. If I do not have insurance, I will be considered a private pay (or self pay) patient and I am financially responsible for the total amount of the services provided. I will notify Weaver Family Dentistry immediately upon any changes to my insurance.

PRIVACY NOTICE ACKNOWLEDGEMENT

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby acknowledge that I have had the opportunity to review a copy of Weaver Family Dentistry, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. Weaver Family Dentistry has the right to revise this notice at any time and will post a copy of the current notice in the office in a visible location at all times. I am aware that Weaver Family Dentistry has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains. Weaver Family Dentistry will provide me with a copy of its most recent notice upon my request.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for dental services rendered to the patient, directly to Weaver Family Dentistry. I hereby authorize Weaver Family Dentistry to release dental information necessary to obtain payment.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges not covered by insurance plan. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Should your account be turned over to collections, an additional fee of 35% will be charged.

BROKEN APPOINTMENT POLICY

Our office requires a 24 hour cancellation notice. Unless appointment is cancelled at least 24 hours in advance, there will be a charge of $45 that will be charged to your account. This charge is to be paid prior to receiving any further treatment.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

PATIENT OR GUARDIAN SIGNATURE:_____**DATE:**_____

Weaver Family Dentistry
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH 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 information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future dental health care.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by which is available in this office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information for treatment, payment or healthcare operations. you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose you health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of you healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of you best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

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 of protected health information of inmate or patient under certain circumstances..

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $10 per record for staff time to locate and copy your health information, and postage if you want the copies mailed to you.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for the purposes other than treatment, payment or healthcare operations described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003.

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 compiaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer @ Telephone: 904-751-6733. Please contact the Privacy Officer for further information about the complaint process.

Weaver Family Dentistry
10490 Balmoral Circle East
Jacksonville, FL 32218
(904)751- 6733