MATTHEW ABDONEY, D.M.D.

ABDONEY
Pediatric Dentistry

2220 E. BLOOMINGDALE AVE.
SUITE A VALRICO, FL 33596
PH. (813) 651-0400
FAX (813) 651-2022

NEW PATIENT INFORMATION

(The information provided is strictly confidential. Please print legibly)

Patient's legal name: ______________________ Preferred name: ______________________

Today's date: __________ Birthdate: __________ Age: __________ Sex: M / F

Address: ______________________ City, State, Zip: ______________________

Home/Cell phone: ______________________ Email address: ______________________

Family members or friends currently or previously seen by us: ______________________

Whom may we thank for referring you to our office? ______________________

RESPONSIBLE PARTY INFORMATION

Father's name: ______________________ Marital Status: Single/ Married/ Widowed/ Divorced

Address: ______________________ City, State, Zip: ______________________

Home/cell phone: ______________________ Work phone: ______________________

Birthdate: ______________________ Employed by: ______________________

Mother's name: ______________________ Marital Status: Single/ Married/ Widowed/ Divorced

Address: ______________________ City, State, Zip: ______________________

Home/cell phone: ______________________ Work phone: ______________________

Birthdate: ______________________ Employed by: ______________________

If divorce is involved, who is the Custodial Parent? ______________________

Email address: ______________________

DENTAL INFORMATION

Previous dentist's name, if any: ______________________

Have you been satisfied with the past dentistry: □ Yes □ No If No, please explain ______________________

Does the patient currently have, or have had any of the following? (please check)

□ Clenching/Grinding
□ Lip Sucking/Biting
□ Gum Surgery
□ Thumb/Finger Sucking
□ Nail Biting
□ Speech Problems
□ Tongue Thrust
□ Mouth Breather
□ Nursing/Bottle Habits
□ Cold Sores
□ Missing or extra permanent teeth, If so please list __________

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MEDICAL INFORMATION

Physician's name: ______________________ Patient's overall health: Excellent / Good / Poor

Is the patient allergic to anything (drugs/food/pollen)? ______________________

Is the patient currently under medical care? □ Yes □ No Where/When? ______________________

Is the patient currently taking any medications? □ Yes □ No Please list: ______________________

Has the patient ever been hospitalized? □ Yes □ No Where/When? ______________________

Does the patient currently have, or had any of the following? (please check)

- □ Abnormal Bleeding
- □ Adenoid Removed
- □ ADD / ADHD
- □ AIDS (HIV)
- □ Asthma
- □ Cancer
- □ Congenital Heart Defect
- □ Diabetes
- □ Epilepsy/Seizures
- □ Handicaps / Disabilities
- □ Hearing impairment
- □ Heart Murmur
- □ Hemophilia
- □ Hepatitis A, B, or C
- □ Immune Disorders
- □ Kidney / Liver Problems
- □ Nasal/Airway Problems
- □ Sinus Problems
- □ Sickle Cell Disease/Traits
- □ Speech Problems
- □ Tonsils Removed
- □ Tubes in Ears
- □ Tuberculosis

Is there any other medical information we should know about? ______________________

____

____

EMERGENCY INFORMATION

Name: ______________________ Relationship to patient: ______________________

Address: ______________________ City, State, Zip: ______________________

Home/cell phone: ______________________ Work phone: ______________________

*Signature (Please sign and date today) ______________________

Update signature ______________________ Update date: ______________________

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DENTAL INSURANCE INFORMATION

(The information provided is strictly confidential. Please print legibly)

Although we accept most insurance, we are *not a participating provider for any insurance company.* This simply means that *you will be responsible for whatever costs your insurance company does not cover.* **Initial here** ___________

We will be happy to assist you in determining your dental insurance benefits, however all information must be completed and signed by the insured party.

Patient's legal name: ______________________ Preferred name: ______________________

Birthdate: ______________________ Age: ______________________ Sex: M / F

PRIMARY DENTAL INSURANCE

Name of insured: ______________________ Birthdate: ______________________

Home Address: ______________________ City, State, Zip: ______________________

Home phone: ______________________ Cell phone: ______________________

SS# of Insured: ______________________ Relationship to patient: ______________________

Employer: ______________________ Occupation: ______________________

Address: ____

City, State, Zip: ______________________ Work phone: ______________________

Insurance company: ______________________ Telephone #: ______________________

ID #: ______________________ Group #: ______________________

Address: ______________________ City, State, Zip: ______________________

I understand that upon my request you will file any charges incurred at your office with my insurance company, however there is no guarantees of coverage and I am ultimately responsible for the account. **Initial here** ___________

I hereby authorize release of any information relating to this claim and authorize payment directly to Abdoney Pediatric Dentistry.

Signature of insured party for primary insurance: ______________________________

Today's date: ______________________

Continued on back page, if secondary insurance applies

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Dental insurance form continued, page 2

SECONDARY DENTAL INSURANCE (If applicable)

Name of insured: ______________________ Birthdate: ______________________

Home Address: ______________________ City, State, Zip: ______________________

Home phone: ______________________ Cell phone: ______________________

SS# of Insured: ______________________ Relationship to patient: ______________________

Employer: ______________________ Occupation: ______________________

Address: ____

City, State, Zip: ______________________ Work phone: ______________________

Insurance company: ______________________ Telephone #: ______________________

ID #: ______________________ Group #: ______________________

Address: ______________________ City, State, Zip: ______________________

I understand that upon my request you will file any charges incurred at your office with my insurance company, however there is no guarantee of coverage and I am ultimately responsible for the account. **Initial here** ____________

I hereby authorize release of any information relating to this claim and authorize payment directly to Abdoney Pediatric Dentistry.

Signature of insured party for secondary insurance: ______________________

Today's date: ______________________

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Authorized persons to bring your child(ren) to dental appointments

Below please list the name, the relationship to the patient, and a phone number of whom you authorize to accompany your child(ren) to any dental visit other than yourself.

Name ______________________ Relationship ______________________ Ph. # __________________

Name ______________________ Relationship ______________________ Ph. # __________________

Name ______________________ Relationship ______________________ Ph. # __________________

Name ______________________ Relationship ______________________ Ph. # __________________

Name ______________________ Relationship ______________________ Ph. # __________________

Name ______________________ Relationship ______________________ Ph. # __________________

Name ______________________ Relationship ______________________ Ph. # __________________

Name ______________________ Relationship ______________________ Ph. # __________________

Name ______________________ Relationship ______________________ Ph. # __________________

Name ______________________ Relationship ______________________ Ph. # __________________

Parent Signature: ____ Date: __________________

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) 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 physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health 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 information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Disease: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and Nation Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Departments 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.

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You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians' practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is the statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health 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.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure or your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

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

You have the right to receive and accounting of certain disclosures we have made, if any, of your protected health information.

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

Complaints: You may complain to us or 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.**

We are required by law to maintain the privacy of, and provided individuals with, this notice of legal duties to privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have reviewed this Notice of our Privacy Practice.

Patient Name: ______________________________ Date: ________________

Responsible Party Name: ______________________________ Relationship to Patient: ____________

Responsible Party Signature: ____