James Family Dentistry, P.A.
685 Royal Palm Beach Blvd, #204
Royal Palm Beach, FL 33411
Office: 561-795-1978
Fax: 561-795-9508
Email: jamesdentistry@aol.com
Website: jamesfamilydentistry.com

SINGLE____ MARRIED____ SEPARATED ____
DIVORCED____ WIDOWED ____

Patient Information

First name: _____ Last name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home/Work Phone: _____ Mobile Phone: _____

Occupation: _____ Best way to contact you: ☐ Home ☐ Mobile ☐ Work

Social Security number: _____ Date of Birth: _____

Emergency Contact: _____ Phone number: _____

Insurance Policy Holder/ Responsible Party (if other than patient)

Subscribers Name:_____Relationship to Patient:_____

Insurance Company:_____Phone number:_____

Employer Name:_____

Social Security Number/ ID number:_____Group #_____

Date of Birth of Subscriber: _____

Dental History

Previous Dentist: _____Date of Last Exam/X-rays: _____

What is the reason for your visit today?: _____

How did you hear about us? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING YES OR NO

Are you having any discomfort? ☐ Yes ☐ No
Are you sensitive to hot, cold or sweets? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Do you take fluoride supplement? ☐ Yes ☐ No
Do you have bleeding gums? ☐ Yes ☐ No
Do you drink coffee or tea? ☐ Yes ☐ No
Do you have bad breath? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you grind your teeth? ☐ Yes ☐ No
Do you play sports? ☐ Yes ☐ No
Do you have difficulty brushing your teeth? ☐ Yes ☐ No
Are you interested in having whiter/brighter teeth? ☐ Yes ☐ No
Have you ever had any type of periodontal therapy? ☐ Yes ☐ No
If YES, please explain _____
How would you rate your SMILE on scale of 1-10, with 10 being the highest? _____

DENTURES/PARTIALS

Do you wear a denture or partial? ☐ Yes ☐ No
If yes, how old is your denture / partial? _____
Are your dentures loose? ☐ Yes ☐ No
Does your denture cause irritation? ☐ Yes ☐ No

MEDICAL HISTORY

Are you under the care of a physician? ☐ Yes ☐ No
Do you use any controlled substances? ☐ Yes ☐ No
Physician name _____
Physicians Phone number_____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
Have you ever been hospitalized or had major surgery? ☐ Yes ☐ No
If YES, please explain _____
WOMEN: Are you pregnant, trying to get pregnant or nursing? ☐ Yes ☐ No
If YES, please explain _____

ARE YOU ALLERGIC TO OR HAVE AN ADVERSE REACTION TO ANY OF THE FOLLOWING:

Aspirin	☐ Yes ☐ No	**Acrylic**	☐ Yes ☐ No	**Sulfa**	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No	**Tetracycline**	☐ Yes ☐ No	**Metal**	☐ Yes ☐ No
Barbituates	☐ Yes ☐ No	**Sedatives**	☐ Yes ☐ No	**Codeine**	☐ Yes ☐ No
Latex	☐ Yes ☐ No	**Local Anesthesia**	☐ Yes ☐ No	**Milk Protein**	☐ Yes ☐ No

Other:

_____

_____

PLEASE CHECK YES OR NO IF YOU HAVE OR HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS

AIDS/HIV+	☐ Yes ☐ No	**ALZHEIMER'S DISEASE**	☐ Yes ☐ No
ANAPHYLAXIS	☐ Yes ☐ No	**ANEMIA**	☐ Yes ☐ No
ANGINA	☐ Yes ☐ No	**ARTHRITIS/GOUT**	☐ Yes ☐ No
ARTIFICIAL HEART VALVE	☐ Yes ☐ No	**ARTIFICIAL JOINT**	☐ Yes ☐ No
ASTHMA	☐ Yes ☐ No	**BLOOD DISEASE**	☐ Yes ☐ No
BLOOD TRANSFUSION	☐ Yes ☐ No	**BREATHING PROBLEM**	☐ Yes ☐ No
BRUISE EASILY	☐ Yes ☐ No	**CANCER**	☐ Yes ☐ No
CHEMOTHERAPY	☐ Yes ☐ No	**CHEST PAINS**	☐ Yes ☐ No
COLD SORES/FEVER BLISTERS	☐ Yes ☐ No	**CONGENITAL HEART DISORDER**	☐ Yes ☐ No
CONVULSIONS	☐ Yes ☐ No	**CORTISONE MEDICATION**	☐ Yes ☐ No
DIABETES	☐ Yes ☐ No	**DRUG ADDICTION**	☐ Yes ☐ No
EASILY WINDED	☐ Yes ☐ No	**EMPHYSEMA**	☐ Yes ☐ No
ENDOCARDITIS	☐ Yes ☐ No	**EPILEPSY OR SEIZURES**	☐ Yes ☐ No
EXCESSIVE BLEEDING	☐ Yes ☐ No	**EXCESSIVE THIRST**	☐ Yes ☐ No
FAINTING SPELLS/DIZZINESS	☐ Yes ☐ No	**FREQUENT COUGH**	☐ Yes ☐ No
FREQUENT DIARRHEA	☐ Yes ☐ No	**FREQUENT HEADACHES**	☐ Yes ☐ No
GLAUCOMA	☐ Yes ☐ No	**HAY FEVER**	☐ Yes ☐ No
HEART ATTACK/FAILURE	☐ Yes ☐ No	**HEART MURMUR**	☐ Yes ☐ No
HEART PACEMAKER	☐ Yes ☐ No	**HEART TROUBLE/DISEASE**	☐ Yes ☐ No
HEMOPHILIA	☐ Yes ☐ No	**HEPATITIS A**	☐ Yes ☐ No
HEPATITIS B OR C	☐ Yes ☐ No	**HERPES**	☐ Yes ☐ No
HIGH BLOOD PRESSURE	☐ Yes ☐ No	**HIVES OR RASH**	☐ Yes ☐ No
HYPOGLYCEMIA	☐ Yes ☐ No	**IRREGULAR HEARTBEAT**	☐ Yes ☐ No
KIDNEY PROBLEMS	☐ Yes ☐ No	**LEUKEMIA**	☐ Yes ☐ No
LIVER DISEASE	☐ Yes ☐ No	**LOW BLOOD PRESSURE**	☐ Yes ☐ No
LUNG DISEASE	☐ Yes ☐ No	**MITRAL VALVE PROLAPSE**	☐ Yes ☐ No
OSTEOPOROSIS	☐ Yes ☐ No	**PAIN IN JAW JOINTS**	☐ Yes ☐ No
PARATHYROID DISEASE	☐ Yes ☐ No	**PARKINSON'S DISEASE**	☐ Yes ☐ No
PINS,RODS,STENTS OR SHUNTS	☐ Yes ☐ No	**PSYCHIATRIC CARE**	☐ Yes ☐ No
RADIATION TREATMENT	☐ Yes ☐ No	**RECENT WEIGHT LOSS**	☐ Yes ☐ No
RENAL DIALYSIS	☐ Yes ☐ No	**RHEUMATIC FEVER**	☐ Yes ☐ No
RHEUMATISM	☐ Yes ☐ No	**SCARLET FEVER**	☐ Yes ☐ No
SHINGLES	☐ Yes ☐ No	**SICKLE CELL DISEASE**	☐ Yes ☐ No
SINUS PROBLEM	☐ Yes ☐ No	**SPINA BIFIDA**	☐ Yes ☐ No
STOMACH/INTESTINAL DISEASE	☐ Yes ☐ No	**STROKE**	☐ Yes ☐ No
SWELLING OF LIMBS	☐ Yes ☐ No	**THYROID DISEASE**	☐ Yes ☐ No
TONSILLITIS	☐ Yes ☐ No	**TUBERCULOSIS**	☐ Yes ☐ No
TUMORS OR GROWTHS	☐ Yes ☐ No	**ULCERS**	☐ Yes ☐ No
VENEREAL DISEASE	☐ Yes ☐ No	**YELLOW JAUNDICE**	☐ Yes ☐ No
NONE OF THE ABOVE	☐		

MEDICATIONS AND/OR SUPPLEMENTS TAKEN IN THE PAST 12 MONTHS:

- ☐ **ANTIBIOTICS OR SULFA DRUGS**
- ☐ **ASPIRIN (DAILY)**
- ☐ **INSULIN OR DIABETES MEDICATION**
- ☐ **HERBAL SUPPLEMENTS**
- ☐ **ANTICOAGULANTS/BLOOD THINNERS**
- ☐ **BISPHOSPHONATES, FOSAMAX, BONIVA, ACTONEL ETC. (USED TO TREAT OSTEOPOROSIS)**
- ☐ **TRANQUILIZER**
- ☐ **CONTRACEPTIVES**
- ☐ **NITROGLYCERINE**
- ☐ **HEART MEDICATIONS**
- ☐ **PHEN-FEN OR REDUX**
- ☐ **HIGH BLOOD PRESSURE MEDICATION**

NAMES OF ALL MEDICATIONS/SUPPLEMENTS YOUR ARE CURRENTLY TAKING:

_____

_____

_____

HAVE YOU EVER HAD BOTOX, JUVADERM OR ANY OTHER INJECTABLE FILLERS PLACED?

_____

I have answered all questions to the best of my knowledge. I will notify the dental health provider of any changes in my health or medications at each visit.

I authorize the dentist/hygienist to use the necessary local/topical anesthesia to perform my treatment in a safe, effective manner during this visit and any future visits. I understand that my failure to provide information on previous adverse reactions may cause unforeseen negative reactions. I release James Family Dentistry, P.A. of all liability regarding undisclosed medical history information.

Our Practice uses email, sent from ciara@jamesfamilydentistry.com, to communicate with patients about the following:

Surveys: asking your opinion regarding your experience at our Practice.

Office Information: (*including but not limited to*) information about changes to office hours, holiday schedules, and weather delays.

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

If authorized guardian, name & relationship **Witness Signature**

_____ _____

Dentist Signature **Date**

NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice in not required to agree to a request restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by representative of patient):_____

AGREEMENT FOR DENTAL SERVICES

The patient hereby retains Dr. Kevin James and/or Dr. Ciara Bone James to render dental services to and for the benefit of the patient. **Initial** _____

The patient/parent agrees to pay promptly all charges, co-pays and insurance deductibles for services provided as they are rendered. **Initial** _____

The patient/parent understands that James Family Dentistry, PA will file dental claims on behalf of the patient in every effort to assist them. The patient/parent understands that failure by any insurance company to pay for any part of their services does not excuse the patient/parent of their obligation to pay the total amount due for services rendered. **Initial** _____

The patient/parent acknowledges that it is <u>not</u> the responsibility of this office to follow-up on any unpaid dental insurance claims. **Initia**l _____

In the event this office finds it necessary to resort to collection action due to an unpaid bill the patient/parent agrees to pay any and all costs, expenses and attorney's fees incurred to collect a bad debt. **Initial** _____

The patient/parent understands James Family Dentistry reserves the right to charge $35 per scheduled hour, for any appointment cancelled or broken or failed without 24 hour's notice. **Initial** _____

Signature of Responsible Party: _____ Date: _____

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name: _____ Date of Birth: _____/____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse_____

☐ Child(ren)_____

☐Other_____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call my home ☐ my work ☐ my cell Number: _____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____