

James Family Dentistry, P.A.

685 Royal Palm Beach Blvd, #204

Royal Palm Beach, FL 33411

Office: 561-795-1978

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Email: jamesdentistry@aol.com

Website: jamesfamilydentistry.com



Patient Information

First name: _____ Last name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acrylic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tetracycline	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Barbituates	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sedatives	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthesia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Milk Protein	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other:

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

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

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

- | | |
|---|---|
| <input type="checkbox"/> ANTIBIOTICS OR SULFA DRUGS | <input type="checkbox"/> TRANQUILIZER |
| <input type="checkbox"/> ASPIRIN (DAILY) | <input type="checkbox"/> CONTRACEPTIVES |
| <input type="checkbox"/> INSULIN OR DIABETES MEDICATION | <input type="checkbox"/> NITROGLYCERINE |
| <input type="checkbox"/> HERBAL SUPPLEMENTS | <input type="checkbox"/> HEART MEDICATIONS |
| <input type="checkbox"/> ANTICOAGULANTS/BLOOD THINNERS | <input type="checkbox"/> PHEN-FEN OR REDUX |
| <input type="checkbox"/> BISPHOSPHONATES, FOSAMAX,
BONIVA, ACTONEL ETC. (USED TO TREAT OSTEOPOROSIS) | <input type="checkbox"/> 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 is 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 not the responsibility of this office to follow-up on any unpaid dental insurance claims. **Initial** _____

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: ____/____/____