PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	☐	If yes	
Do you use controlled substances?	Yes No	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Nabors Family and Cosmetic Dentistry

133 NW Beal Pkwy | FORT WALTON BEACH FL, 32548 | (850) 362-6898

Written Financial Agreement

Thank you for choosing the office of Dr. Lygia Nabors. Our primary mission is to deliver comprehensive dental care to our patients. An important part of our mission is to make the cost of dental treatment easy and manageable for our patients as possible by providing you with multiple payment options.

Available Payment Options:

- Cash, Check, Visa, MasterCard, American Express, Discover, Care Credit

Payment is due in full at the time of service. For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement of your treatment. We cannot guarantee payment from the insurance company and all balances are ultimately the responsibility of the patient/responsible party. Our office staff strives to make every effort to advise our patients of their estimated financial responsibility. Your dental insurance policy is an agreement between you and your employer and you are ultimately responsible for all dental fees relating to your care. All co-payments and deductibles are due at the time of service.

If at any time you have any questions about treatment or financial estimates, please notify a staff member promptly as we value an open and honest financial relationship with all of our patients.

My signature below, acknowledges that I agree to the above financial agreement

_____ _____

Patient Signature Date

Nabors Family and Cosmetic Dentistry

133 NW Beal Pkwy | FORT WALTON BEACH FL, 32548 | (850) 362-6898

Consent for Treatment

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that might require additional treatment
- Delayed healing of an extraction site, (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date
- Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Failure of the dental procedure necessitating additional treatment
- Breakage of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I, the undersigned, understand and authorize the doctor to take radiographs (x-rays), study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I assume the right and responsibility to ask for any risks of treatment, alternative treatments, as well as the financial responsibility of the treatments.

I understand that the use of local anesthetics embody a certain risk. Complications and side effects are rare, but may include, among others not listed: Swelling, bruising or soreness at the injection site, numbness outside of the mouth, temporary rapid heartbeat, damages to the nerves resulting in temporary or possibly permanent numbness or tingling of lips, chin, tongue or other areas, severe allergic and possible life threatening reactions necessitating emergency care. I understand that if I have high blood pressure, uncontrolled thyroid problems, angina or have recently had a heart attack that I will inform my dentist verbally without fail as these conditions have caused complications for persons receiving local anesthesia. I assume the right and responsibility to ask for any alternative treatments, as well as the financial responsibility of the treatments.

I confirm that I am over the age of 18 years old (If not please stop and notify the front desk). I understand that I am responsible for payment for the services provided for myself, or my dependents and it is payable at the time of services rendered or by the Financial Policies guidelines that I have read and understand. I authorize payment to be issued by my insurance carrier directly to this office. I also understand that any balance from the insurance company that is not resolved after 45 days is my responsibility. In the event an account is turned over to an attorney, I agree to pay all reasonable attorney fees, court cost and other cost associated with the collection of the account. My signature acknowledges that I have asked and have had answered any and all questions associated with any of the above issues.

_____ _____

Patient Signature Date

Nabors Family and Cosmetic Dentistry

133 NW Beal Pkwy | FORT WALTON BEACH FL, 32548 | (850) 362-6898

Consent for Internet Communications

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information:

· We may have to disclose your health information to another health care provider or a hospital if it is necessary for our office to refer you to them for consultation or treatment.

· We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.

· We may need to use your personal information to remind you of your appointments.

I understand that all email communications in which I engage may be forwarded to other providers for the purposes of providing treatment to me. This may include but not be limited to sending your x-rays and/or minimal personal information to other providers via email. We strive to keep all patient information secure but unfortunately there is no assurance of confidentiality of information when communicating this way.

My signature below, acknowledges that I have read and understand this policy and agree to the terms.

_____ _____

Patient Signature Date

Nabors Family and Cosmetic Dentistry

133 NW Beal Pkwy | FORT WALTON BEACH FL, 32548 | (850) 362-6898

CANCELLATION & MISSED APPOINTMENT POLICY

At Nabors Family & Cosmetic Dentistry, we strive to provide superior dental care for all of our patients. When we schedule an appointment, a specific amount of time is reserved especially for you. In an attempt to be consistent with providing excellent quality dentistry, we have an appointment cancellation policy which allows us to schedule appointments for all patients, in case an appointment must be missed.

If for any reason you must cancel or change your appointment, we require that you give our office at least 24 hour notice. This allows our office time to schedule a patient into that appointment. If you miss an appointment without contacting our office within the required time, this will be considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.

When time is reserved for you, we do require all of that time to provide the best quality in dental care. When you are late, it decreases our ability to accomplish this. Regarding late arrivals to appointments, if a patient is more than 15 minutes late for an appointment without prior notice to our office, we will consider this a missed appointment, and a $50.00 cancellation fee will be billed to the patient.

Also, **CONFIRMATION IS REQUIRED**, we do reserve the right to remove your appointment from our schedule, if your appointment is not confirmed in a timely manner. We have established different methods to confirm your appointment to accommodate your needs. This does include reminders by phone, text messaging, and e-mail.

Appointments can be cancelled and rescheduled by contacting our dental office via phone or e-mail. Our contact information is as follows:

Office phone number: (850)362-6898

Office e-mail address: admin@naborsdental.com

If you have any questions regarding this policy, please let our staff know, and we will be glad to clarify any questions you may have.
We thank you for the opportunity to treat your dental needs.
I have read and understand the Appointment cancellation Policy of Nabors Family & Cosmetic Dentistry and I agree to be bounded by its terms. I also agree and understand that such terms may be amended from time-to-time by the practice.

_____ _____

Patient Signature Date

Nabors Family and Cosmetic Dentistry

133 NW Beal Pkwy | FORT WALTON BEACH FL, 32548 | (850) 362-6898

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 IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

When a state or federal law mandates that certain health information be reported for a specific purpose;

for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations uses or disclosures for health related research; uses and disclosures to prevent a serious threat to health or safety; uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service; disclosures of de-identified information; disclosures relating to worker's compensation programs; disclosures of a "limited data set" for research, public health, or health care operations; incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information; Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your

Request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Date