

PATIENT NAME: _____ AGE: _____
 DATE OF BIRTH: _____ GENDER: M F HEIGHT: _____ WEIGHT: _____
 ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____
 EMAIL: _____ PHONE: _____
 GENERAL DENTIST: _____ DENTIST PHONE: _____
 PRIMARY CARE PHYSICIAN/MD: _____ PHYSICIAN PHONE: _____
 DATE OF LAST MEDICAL EXAM: _____ CURRENT HEALTH: GOOD | FAIR | POOR
 Have you ever tested positive for COVID-19? Yes No If yes, when? _____ Vaccine? _____

PLEASE CHECK ALL THAT APPLY:

- Heart attack | Date: _____
 - Heart Stent | Date: _____
 - Chest pain/angina/pressure with activity
 - Heart failure
 - Heart surgery/Bypass | Date: _____
 - Heart stent In the last 6 months
 - Implanted heart device
 - Pacemaker/LVAD Defibrillator
 - Artificial Heart Valve | Type: _____
 - Transcatheter aortic valve replacement (TAVR) Closed Open
 - Atrial Fibrillation
 - Arrhythmia (Abnormal Heartbeat)
 - Congenital Heart Disease
 - Hypertension (High Blood Pressure)
 - Murmur/Valve Noise
 - Unable to climb 2 flights of stairs/walk 2 blocks due to chest pain/trouble breathing
 - Pain in legs while walking
 - Phlebitis or Blood Clots
- CARDIOLOGIST _____
 PHONE NUMBER _____

NEUROLOGICAL

- Stroke
- Aneurysm
- Seizure
- Paralysis
- Leg Pain
- Psychiatric Problems
- Epilepsy
- Spinal cord stimulator
- Fainted in the last year
- Parkinson's Disease
- Neuromuscular Disease

PULMONARY

- Oxygen at home
 - Pulmonary Hypertension
 - Trouble breathing at rest/Shortness of breath
 - Asthma
 - COPD
 - Pneumonia (in last 2 mos)
 - Tuberculosis
 - Chronic cough
 - Any other lung issues
- PULMONOLOGIST _____
 PHONE NUMBER _____

ALLERGIES

- Eggs Latex None
- List all drug allergies: _____

MEDICATION

Have you ever taken:	Yes	No
Risedronate (Actonel®)	<input type="checkbox"/>	<input type="checkbox"/>
Ibandronate (Boniva®)	<input type="checkbox"/>	<input type="checkbox"/>
Alendronate (Fosamax®)	<input type="checkbox"/>	<input type="checkbox"/>
Pamidronate (Aredia®)	<input type="checkbox"/>	<input type="checkbox"/>
Zoledronate (Zometa®)	<input type="checkbox"/>	<input type="checkbox"/>
Zoledronate (Reclast®)	<input type="checkbox"/>	<input type="checkbox"/>

How Long _____
 Last Dose _____

PATIENT NAME: _____

ANTI-RESORPTIVE & ANTI-ANGIOGENIC MEDICATION CLARIFICATION

- Denosumab cycle tracking (Prolia®/Xgeva®)
- VEGF inhibitors (Avastin®, Sutent®)
- Nexavar (Sorafenib®)

Reason for therapy:

- Breast CA
- Prostate CA
- Osteoporosis/Osteopenia
- Bone Metastasis
- Other: _____

- Continuous dosing
- Intermittent dosing

Last oncology follow-up date _____

AIRWAY & ANESTHESIA SAFETY

- Have you or a blood relative ever had problems with general anesthesia, local anesthesia and or intravenous sedation?

PLEASE EXPLAIN _____

- Difficulty waking up
- Sensitive to pain medication/sleeping pills?
- Being treated for a chronic pain condition?
- Difficult IV access
- History of POTS / dysautonomia
- History of SVT / tachyarrhythmias
- History of motion sickness, nausea or vomiting after surgery?
- Malignant hyperthermia (self or family)
- Breathing difficulty lying flat
- Limited neck mobility
- Snoring or witnessed apnea
- Previous difficult intubation
- Difficulty walking? Do you use:
- Cane Walker Wheelchair

INFECTIOUS DISEASE SCREEN

- Long COVID symptoms (POTS-like dysautonomia)
- Recent pneumonia/RSV requiring inhalers

Immunocompromised status:

- Anti-rejection/Transplant medications (e.g., tacrolimus, cyclosporine, mycophenolate)
- Other: _____

SEDATION PREFERENCES:

Preferred Sedation Type _____

GI/HEPATIC

- Hiatal Hernia
- Hepatitis A B C
- Other Liver Diseases: _____

ORTHOPEDIC

- Artificial Replacement
- Arthritis
- Osteoporosis
- Osteoarthritis

Joints Affected: _____

- Fibromyalgia
- Rheumatoid

SOCIAL HISTORY

- Tobacco Use
 - Smokeless
 - SmokingHow Often: _____
- Marijuana
 - Smoked EdibleHow Often: _____
- Alcohol? How Often: _____
- Vaping? How Often: _____
- Testosterone / steroid use
- Pre-Workout Supp.
- Other illicit drugs
- Eating disorder

FEMALES

- Pregnant
- Nursing
- Trying to conceive

Last Menstrual Period: _____

DENTAL ANXIETY SCALE (CIRCLE ONE)

1 2 3 4 5 6 7 8 9 10
(least anxious) (most anxious)

Past Bad Dental Experiences _____

CANCER

- Melanoma
- Basal Cell
- Squamous Cell
- Radiation to head/neck
- Chemotherapy

If yes, last date of treatment: _____

TMJ, TRAUMA, NEUROLOGIC SYMPTOMS

- History of facial trauma
- Chronic headaches
- Trigeminal neuralgia
- Known neuropathies
- Childhood radiation to head/neck
- Prior orthodontic extractions/jaw surgery
- Clicking of jaw joint
- Locking of the jaw

SLEEP APNEA (Check only if YES)

- Do you use a CPAP?
- Uses CPAP nightly? AHI Level? _____
- Diagnosed but untreated?
- Do you sleep elevated with more than 1 pillow?
- Do you SNORE loudly?
- Often tired/sleepy during the day?
- Has anyone observed you stop breathing during sleep?

PATIENT NAME: _____

RENAL/ENDOCRINE		OTHER	
<input type="checkbox"/> Kidney Transplant	Diabetes	<input type="checkbox"/> HIV	<input type="checkbox"/> _____
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Implanted Bladder Device	_____
<input type="checkbox"/> Hypothyroid	Avg Blood Sugar Level:	<input type="checkbox"/> Cochlear Implant	<input type="checkbox"/> _____
<input type="checkbox"/> Hyperthyroid	_____ to _____	<input type="checkbox"/> Pain Pump	_____
<input type="checkbox"/> Graves	Insulin Pump <input type="checkbox"/>	<input type="checkbox"/> Eye Disease	<input type="checkbox"/> _____
<input type="checkbox"/> Addison's	Last AIC Level: _____	<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Dialysis/Kidney Failure		<input type="checkbox"/> Cataracts	
		<input type="checkbox"/> Surgery Date: _____	
		<input type="checkbox"/> Macular Degeneration	

Semaglutide / GLP-1 Delay-Gastric-Emptying Policy

GLP-1 medications (Ozempic, Wegovy, Mounjaro, Zepbound, etc.) may delay gastric emptying and increase anesthesia risk.

I agree to follow the office policy regarding withholding these medications before IV sedation or general anesthesia.

On weekly GLP-1
 On daily GLP-1
Last dose: _____

PHARMACY NAME _____

LOCATION _____

PHONE _____

ALL Medications, Dosage, and Frequency

Check here if not on any medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PAST SURGICAL HISTORY

Do you wish to talk with the doctor privately about anything? _____

MUTUAL UNDERSTANDING

The statements on this form are true to the best of my knowledge.

SIGNATURE - Patient or Legal Guardian (if minor)

PRINT NAME - Patient or Legal Guardian

FINANCIAL/INSURANCE



FINANCIAL

Payment is due at the time of service

I hereby authorize my insurance company to pay all benefits directly to Rintel Oral Surgery, PLLC. I understand that execution of this agreement in no way relieves me of my financial responsibility.

SIGNATURE

PRINT NAME

DATE

By signing below, I understand that I am responsible for this account and agree to pay all un-paid balances, including a 1.5% service charge accrued monthly on all balances outstanding over 60 days.

SIGNATURE

PRINT NAME

DATE

INSURANCE

Patients Name _____ Name of Subscriber _____

Insurance Company _____

DOB of Subscriber _____ Employer of Subscriber _____

Group # or Social Security # of Subscriber _____

I acknowledge and understand that I will be provided an estimate obtained from my insurance company. I understand this information is NOT A GUARANTEE OF PAYMENT. Insurance companies pay based on "Reasonable & Customary" fee schedules, which often results in less payment than expected. I acknowledge and understand that I will be billed and fully responsible for any amount due or balances on this account not covered by my insurance.

SIGNATURE

PRINT NAME

DATE

IMPLANT RISK ACKNOWLEDGEMENT



I acknowledge that I have been informed of and understand the following regarding dental implant treatment:

Peri-implantitis Risk: Dental implants are subject to inflammatory conditions, including peri-implantitis, which can result in bone loss and potential implant failure if not properly managed.

Lifelong Hygiene Maintenance: Successful implant treatment requires lifelong oral hygiene, routine professional cleanings, and regular follow-up visits. Failure to maintain these standards increases the risk of complications.

Implant Longevity: I understand that dental implants may fail even when placed and restored under ideal clinical conditions.

Bruxism (Clenching/Grinding): I acknowledge that clenching or grinding my teeth (bruxism) is a known risk factor that can negatively affect implant longevity, prosthetic components, and surrounding bone.

Smoking & Implant Survival: I understand that tobacco use significantly reduces implant success rates and increases the risk of infection and implant failure.

Diabetes Management: I acknowledge that uncontrolled diabetes increases surgical and implant failure risks. I understand that an acceptable HbA1c level is required for treatment eligibility and may be monitored before and during care.

Sinus Grafting Risks (When Applicable): I understand that sinus grafting procedures carry specific risks, including but not limited to sinus membrane perforation (oroantral communication), sinusitis, graft migration, and the need for additional treatment.

Full-Arch Prosthetic Materials: I understand that full-arch restorations have material-specific limitations. Acrylic prostheses may wear, stain, or fracture over time, while zirconia restorations, though stronger, may still chip or fracture under certain conditions.

Conversion Denture Disclosure: I understand that a conversion (temporary) denture is not my final prosthesis and is intended for interim use during healing and treatment progression.

By signing below, I confirm that I have had the opportunity to ask questions, that all my questions have been answered to my satisfaction, and that I agree to proceed with treatment with full understanding of the above risks, responsibilities, and limitations.

SIGNATURE

PRINT NAME

DATE

OPIOID CONSENT & NON-OPIOID ALTERNATIVES

I understand that opioid medications:

- May impair my ability to drive or operate machinery
- Carry a risk of dependence and addiction
- Can be reversed with naloxone, which is available
- Are not the only option; alternatives may include NSAIDs, acetaminophen, TXA, or gabapentin

I acknowledge and accept these risks.

SIGNATURE

PRINT NAME

DATE

PATIENT HIPAA ACKNOWLEDGEMENT & DESIGNATION DISCLOSURE FORM



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

By signing below I acknowledge that I was provided a copy of the Notice of Privacy Practices(NPP), and that I have read(or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to it's terms.

I AGREE THAT MY INFORMATION MAY BE LEFT VIA: VOICEMAIL TEXT EMAIL

SIGNATURE

PRINT NAME

DOB

DATE

DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:

I agree that the practice may disclose details of my health information to a personal Representative of my choosing since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

REPRESENTATIVE AUTHORIZED FOR DISCLOSURE OF INFO

REPRESENTATIVE AUTHORIZED FOR DISCLOSURE OF INFO

SIGNATURE

DATE

WITNESS

DATE

IMAGE CONSENT



PRINT PATIENT'S NAME

I consent that my photograph or likeness (the "IMAGES" and the entire text of, excerpts from, or a part of any letters, e-mails or other communications I have sent to Rintel Oral Surgery PLLC (the "Practice"), or any of its dentists or other personnel (the "Communications"), may be used by the Practice under the following conditions.

The Images, negatives, prints or copies thereof and the Communications may be used for educational, medical, marketing and promotional purposes for the Practice and its services, and its dentists. They may be published and republished, either separately or in connection with each other, on websites, in magazines, newspaper or other periodicals, television or other marketing and promotional materials of the Practice, or used for any lawful purpose that the Practice may deem appropriate.

I specifically consent to my procedure and treatment by the Practice being videotaped and authorize the Practice to use all or portions of such video for advertising purposes, whether on television, websites or any media or for any other lawful purpose that the Practice may deem appropriate.

I understand that the Images may be modified or retouched in any way that the Practice, in its discretion, may consider desirable, and that portions or excerpts of the Communication for use by the Practice may be determined as the Practice deems appropriate.

I understand that the Images and Communications received by the Practice are and will remain the exclusive property of the Practice and I will have no right, title or interest in them whatsoever.

By consenting to the use of the Images and the Communications as set forth above, I understand that I will not receive payment from any party. I understand that refusal to consent to use the Images and the Communication will in no way affect the medical care I will receive.

ACCEPT

DECLINE

SIGNATURE

PRINT NAME

DATE

SIGNATURE OF WITNESS

DATE

DIGITAL COMMUNICATIONS AND AI POLICY

I understand that the practice may use HIPAA-compliant digital tools (texting, online forms, AI-assisted scheduling or responses). These tools do not replace professional medical advice.

SIGNATURE

PRINT NAME

DATE

PRE OPERATIVE INSTRUCTIONS ACKNOWLEDGEMENT AGREEMENT



To ensure your safety and the success of your procedure, please read each policy carefully. By signing below, you acknowledge that you understand and agree to follow all pre-operative instructions.

NPO (Nothing by Mouth) Policy: I understand that I must not eat or drink anything for the time period instructed prior to my procedure. This includes food, beverages, gum, candy, mints, and chewing tobacco, unless specifically directed otherwise by the office.

Adult Escort Requirement: I understand that if I am receiving sedation, I must arrive with a responsible adult (18 years or older) who will remain in the office during my procedure and escort me home afterward.

No Rideshare or Public Transportation: I understand that Uber, Lyft, taxis, buses, or other rideshare/public transportation are not permitted following sedation. My escort must be someone I personally know and trust.

Alcohol Restriction: I understand that I must not consume alcohol for at least 24 hours prior to my procedure, as alcohol can interfere with anesthesia and increase surgical risk.

Cannabis Restriction: I understand that I must not use cannabis (including marijuana, THC, edibles, vapes, or related products) for at least 72 hours prior to my procedure, as it can significantly affect anesthesia and sedation safety.

Medication Disclosure: I understand that I must notify Rintel Oral Surgery, PLLC before my procedure if I am taking:

- Blood thinners (such as warfarin, Eliquis, Xarelto, Plavix, aspirin, etc.)
- GLP-1 medications (such as Ozempic, Wegovy, Mounjaro, Trulicity, or similar)
- Failure to disclose this information may result in procedure delay or cancellation for safety reasons.

Acknowledgement & Consent: I acknowledge that I have read and understand all pre-operative and sedation instructions listed above. I understand that failure to follow these instructions may result in cancellation or re-scheduling of my procedure for my safety.

I agree to comply with all requirements and will contact the office if I have any questions or changes in my health or medications.

SIGNATURE

PRINT NAME

DATE

DENTAL HISTORY

PATIENT NAME _____

DATE OF BIRTH _____

Please describe your current dental health: **EXCELLENT** | **GOOD** | **FAIR** | **POOR**

Is this your first consultation regarding dental implants? **YES** | **NO**

Please explain what symptoms or tooth related concerns prompted this visit.

- | | | |
|---|---|--|
| <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Lack of social interaction | <input type="checkbox"/> Failing dental work |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Dentures/Partials | <input type="checkbox"/> Broken teeth |
| <input type="checkbox"/> Infected teeth | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Failing dental implants |
| <input type="checkbox"/> Facial swelling | <input type="checkbox"/> Embarrassment | <input type="checkbox"/> Other |
| <input type="checkbox"/> Missing teeth | | |

COMMENTS: _____

Have you ever been diagnosed with periodontal disease? **YES** | **NO**

If Yes, do you currently have loose teeth? **YES** | **NO**

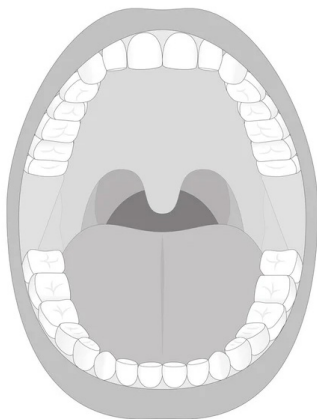
Please specify what treatment you are most interested in: _____

DENTURES

How long have you worn dentures? _____

What is your chief complaint?

- Ill-Fitting/Pain
- Difficulty chewing
- Gag reflex
- Other: _____
-



Shade or mark the area(s) of your mouth that are in pain in the diagram.

Notes: _____

SIGNATURE

PRINT NAME

DATE

RINTEL ORAL SURGERY, PLLC

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.

Effective Date: December 22, 2025

Rintel Oral Surgery, PLLC (“we,” “our,” or “the Practice”) is committed to protecting the privacy of your health information. This Notice explains how we may use and disclose your protected health information (“PHI”), and how you can access and control your information.

1) Our Responsibilities

We are required by law to:

- Maintain the privacy and security of your protected health information.
- Provide you with this Notice of our legal duties and privacy practices.
- Follow the terms of this Notice currently in effect.
- Notify you if a breach occurs that may have compromised the privacy or security of your information.
- We reserve the right to change this Notice. Any changes will apply to all health information we maintain. An updated Notice will be available in our office and on our website.

2) How We May Use and Disclose Your Health Information (Without Additional Authorization)

A. Treatment: We may use and disclose your PHI to provide, coordinate, or manage your oral surgery care and related services. Examples: discussing your diagnosis, surgical procedures, anesthesia, medications, imaging, referrals, and follow-up care with other healthcare providers involved in your treatment.

B. Payment: We may use and disclose your PHI to bill and collect payment for services provided. Examples: submitting claims to dental or medical insurance plans, verifying coverage, responding to benefit inquiries, and collecting balances.

C. Healthcare Operations: We may use and disclose your PHI for healthcare operations necessary to run our practice and ensure quality care. Examples: quality improvement activities, staff training, credentialing, licensing, audits, accreditation, and business planning.

3) Other Uses and Disclosures We May Make

A. Appointment Reminders and Practice Communications: We may contact you to remind you of appointments or provide information related to your treatment or services offered by the Practice.

B. Individuals Involved in Your Care or Payment: We may disclose relevant PHI to a family member, friend, or other person involved in your care or payment for your care, unless you object. If you are unable to agree or object, we may disclose information we believe is in your best interest.

C. Business Associates: We may disclose PHI to third parties that perform services on our behalf (such as billing companies, IT providers, cloud storage services, or shredding services). These business associates are required by law to safeguard your PHI.

D. As Required by Law: We will disclose PHI when required by federal, state, or local law.

E. Public Health and Safety: We may disclose PHI for public health activities and safety purposes, including reporting diseases, adverse reactions to medications, product recalls, or suspected abuse or neglect, as permitted or required by law.

F. Health Oversight Activities: We may disclose PHI to health oversight agencies for activities authorized by law, such as audits, inspections, investigations, and licensure actions.

G. Judicial and Administrative Proceedings: We may disclose PHI in response to a court order, subpoena, or other lawful process, as permitted by law.

H. Law Enforcement: We may disclose PHI to law enforcement officials as required or permitted by law.

I. Coroners, Medical Examiners, and Funeral Directors: We may disclose PHI to coroners, medical examiners, and funeral directors as permitted by law.

J. Workers' Compensation: We may disclose PHI as authorized by and to the extent necessary to comply with workers' compensation laws.

RINTEL ORAL SURGERY, PLLC

NOTICE OF PRIVACY PRACTICES

4) Uses and Disclosures Requiring Your Written Authorization: We will not use or disclose your PHI for the following purposes unless you provide written authorization:

- Most uses and disclosures of psychotherapy notes (if applicable)
- Marketing purposes (with limited exceptions)
- Sale of your PHI

You may revoke your authorization in writing at any time, except to the extent that we have already relied on it.

5) Your Rights Regarding Your Health Information

You have the right to:

A. Inspect and Obtain Copies: Request to inspect or obtain a copy of your medical and billing records. We may charge a reasonable, cost-based fee.

B. Request an Amendment: Ask us to correct or amend your records if you believe information is incorrect or incomplete.

C. Request Restrictions: Ask us to limit how we use or disclose your PHI. We are not required to agree to most requests. If you pay out-of-pocket in full for a service and request that we not disclose that information to your health plan, we will honor that request unless disclosure is required by law.

D. Request Confidential Communications: Request that we contact you in a specific way or at a specific location (for example, phone, email, or alternate address). Reasonable requests will be accommodated.

E. Receive an Accounting of Disclosures: Request a list of certain disclosures of your PHI made in the past six (6) years, excluding disclosures for treatment, payment, and healthcare operations.

F. Obtain a Paper Copy of This Notice: Request a paper copy of this Notice at any time, even if you have agreed to receive it electronically.

G. Designate a Personal Representative: If someone has legal authority to act on your behalf, that person may exercise your rights after proper documentation is provided.

6) Electronic Communications: If you request communication by email, text message, or other electronic means, you acknowledge that such methods may not be fully secure. You may change your communication preferences at any time.

7) Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services Office for Civil Rights. You will not be retaliated against for filing a complaint.

8) Contact Information

Privacy Officer: Geoffrey Rintel, DMD
Rintel Oral Surgery, PLLC

208 Avenue A NW, Winter Haven, FL 33881
Phone: 863-216-8310
Email: info@rinteloralsurgery.com
Website: www.rinteloralsurgery.com

9) Acknowledgement of Receipt

We may ask you to sign an acknowledgement confirming that you received this Notice. If you choose not to sign, we will document that we provided it to you.