

Bradley Schiff, D.D.S.

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**PLEASE PRINT**

Ms. Mrs. Mr. Dr. \_\_\_\_\_ Date \_\_\_\_\_

Residence Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec. # \_\_\_\_\_

Telephone - Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Referring Dentist \_\_\_\_\_ \*Do you have any referral information with you?  Yes  No

Person **responsible** for this account, if not the patient:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Name of **Insured** \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ Group# \_\_\_\_\_

**MEDICAL INFORMATION**

**Please check any of the following that apply:**

- |  |  |
|--|--|
| <input type="checkbox"/> Latex Allergy       | <input type="checkbox"/> Antibiotic Pre-Medication for ALL dental visits |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Replacement: Date: _____                  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Condition: _____                          |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Heart Valve Replacement                         |
| <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Pregnant or Nursing                             |

If you answer **YES** to any of the following questions, **PLEASE EXPLAIN BELOW:**

- Are you currently under the care of a physician for any reason?  YES  NO
- Have you ever had any serious illness or been hospitalized for any major reason?  YES  NO
- Have you had IV chemotherapy?  YES  NO
- Are you or have you recently taken medication for osteoporosis or bone loss?  YES  NO  
(Including Fosamax, Boniva, and Actonel)

• LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

*\*If you are taking Birth Control pills and are on Antibiotics, Please be aware the birth control pills may be less reliable, and alternative contraceptive measures should be considered.*

• ALLERGIES? (Please List):

Name of Family Physician \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

**OFFICE POLICY:** I hereby acknowledge that Endodontic Associates will provide a complete consultation and explanation before any treatment is initiated. If treatment has been scheduled, I hereby acknowledge I / my child is in need of root canal therapy and give my permission for the doctors of Endodontic Associates to provide such services and procedures as deemed necessary to complete my endodontic treatment plan. I hereby give my permission to release confidential information to my insurance company in an attempt to file for dental benefits. A photo ID has been obtained for my protection from identity theft.

**We require a 48 hour cancellation notice for all appointments.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

After endodontic therapy, a permanent restoration (crown or filling) will be required for the preservation of your tooth. Your family dentist will provide this service. A narrative and x-ray will be sent detailing your endodontic therapy procedure.

**Endodontic Associates of Brevard, PA**

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## And Acknowledgement of Receipt of Notice of Privacy Practices

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Business Manager Telephone: 321-253-8500 Fax: 321-254-6111 Address: 645 Classic Court, Suite 102, Viera, FL 32940

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

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### CONSENT AUTHORIZATION

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. Dental treatment information may be released to all providers involved in my care along with supporting documentation such as x-rays and correspondence.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Endodontic Associates of Brevard, PA

#### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained:

- Individual refused to sign       Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement       Other (Please Specify)

\*You May Refuse to Sign This Acknowledgement \*