Oasis Dental
610 N. Mills Ave. Suite 200
Orlando, FL 32803
Phone: (407)674-8770

Welcome to Oasis Dental! Please fill out the following information for the staff to be able to get to know you. Thank you for becoming part of the family.

First Name:_____Last Name:_____Middle Initial_____

Preferred Name_____ Responsible Party Name (if under18)_____

Who may we thank for referring you?_____(Please ask about the special referral program)

Address_____Apt_____

City, State,
Zip:_____

Home Phone:_____Work Phone:_____ext_____

Cell Phone:_____Emergency Phone/Contact_____

Martial Status: ___Married ____Single____Divorced___Separated___Widowed

Birthdate:_____ Social Security:_____Drivers Lic:_____

Email:_____

Insurance Information:

Name of Insurance:_____Phone Number:_____Group number:_____

Address:_____Employer:_____

Please give card to front desk

Policy Holder Information: (if different from patient)

Name of insured:_____Relationship to Policyholder_____

Policy holder ID number or Social Security:_____D.O.B_____

Please Circle 'Yes' or 'No' if you have or had any of the following:

Aids/ Hiv	Yes	No
Alzheimer's Disease	Yes	No
Anaphylaxis	Yes	No
Anemia	Yes	No
Angina / Chest Pain	Yes	No
Arthritis/Gout	Yes	No
Artificial Heart Valve	Yes	No
Artificial Joint	Yes	No
Asthma	Yes	No
Blood Disease	Yes	No
Breathing Problem	Yes	No
Bruise Easily	Yes	No
Cancer	Yes	No
Chemotherapy	Yes	No
Cold Sores/ Fever Blisters	Yes	No
Congenital Heart Disorder	Yes	No
Cortisone Medicine	Yes	No
Diabetes	Yes	No
Drug Addiction	Yes	No
Easily Winded	Yes	No
Emphysema	Yes	No
Convulsions/Epilepsy/ 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
Heart Attack/ Failure	Yes	No
Heart Murmur	Yes	No
Heart Trouble/ Disease	Yes	No
Hemophilia	Yes	No
Hepatitis A,B, or C	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	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 Joint	Yes	No
Parathyroid Disease	Yes	No
Psychiatric Care	Yes	No
Radiation Treatments	Yes	No
Recent Weight Loss	Yes	No
Rheumatic Fever	Yes	No
Rheumatism	Yes	No
Scarlet Fever	Yes	No
Shingles	Yes	No
Sickle Cell Disease	Yes	No
Sinus Trouble	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
Jaundice	Yes	No

Women:

Pregnant/ Trying	Yes	No
Nursing	Yes	No
Taking oral contraceptives	Yes	No

Allergic to:

Aspirin	Yes	No
Penicillin	Yes	No
Codeine	Yes	No
Local Anesthetics	Yes	No
Acrylic	Yes	No
Metal	Yes	No
Latex	Yes	No
Sulfa Drugs	Yes	No

Other_____

Please Sign and Date: x_____ x_____

Medical History

It is very important to inform the dental staff of any medical conditions or medications taken. Please fill out the following as best you can. If you check 'Yes' to a question please explain. Thank You!

1) Are you under a physician's care now? Yes No – If yes please explain:_____
2) Have you ever been hospitalized or had a major operation? Yes No –if yes please explain:_____
3) Have you ever had a serious head or neck injury? Yes No—if yes please explain:_____

4) Are you taking any Medications, Pills,Drugs, over the counter medicines(including Aspirin)? Yes No ---**If Yes Please write down all names and amounts:**_____
_____
_____
If you have a list already written give to front desk.

5) Do you take, or have you taken,Phen-Fen or Redux? Yes No---if yes please explain:_____

6) Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No—If yes please explain:_____

7) Are you on a special Diet? Yes No—If yes please explain:_____

8) Do you use tobacco/tobacco products? Yes No—If yes please explain:_____

9) Do you use recreation drugs? Yes No—If yes please explain:_____

10) Are you taking any vitamins or natural supplements? Yes No—if yes please explain:-
_____

Please Sign_____Date_____

Financial Policy

Please read **BEFORE** signing:

_____: I am aware that Oasis Dental is a third party to my insurance company. Oasis Dental is billing my insurance out of a courtesy to me. I understand that any treatment that I choose to have done I am responsible for the total fee. Any estimates that the dental office gives me are just estimates; your insurance company will make the final decision. If there are any dental services that are not paid for by the insurance company, I understand that I will be responsible for the remaining amounts.

__: I understand that before I do any treatment that I can request that the full fee be shown to me up front so I know ahead of time what the full fee is before any services are render.

__: I understand that my portion of any dental services is due in **FULL** when services are render.

__: I understand that they may be payment options available for me; but I will have to make payment arrangements before any dental services are done.

__: Any checks that are returned due to Non Sufficient Funds there will be a return check fee of $30 plus the balance of the original check; If a bad check is written we will be unable to accept any more checks from you in the future.

__: Cancellation fee of $25 is applied if you cancel your appointment without a 48 hour notice.

If you have any questions about this finical policy please talk to the dental staff. Thank you.

Please sign and date

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Fax: (407)674-8772

Notice of Privacy Practices for Protected Health Information

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing out services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have the right to:

*Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;

*Request that you be allowed to inspect and copy your health record and billing record- you may exercise this right by delivering the request in writing to our office;

*Appeal a denial of access to your protected health information except in certain circumstances;

* Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;

* File a statement of disagreement if your amendment is denied, and require to be maintained by law by delivering a written request to our office. An accounting will NOT include internal uses of information for treatment, payment, or operation, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;

*Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,

*Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Dawn Holmes at 407-674-8770 located at 610 N. Mills Ave Suite 200 Orlando, FL 32803, in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to : Maintain the privacy of your health information as required by law; Provide you with a notice of our duties and privacy practices as to the information we collect and maintain

about you; Abide by the terms of this Notice; Notify you if we cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the riht to amend,change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend out Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking a copy.

To Request Information or File a Complaint

If you have any question, would like additional information, or want to report a problem regarding the handling of your information, you may contact Oasis Dental 407-674-8770

Additionally if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Oasis Dental Staff. You may also file a complaint by mailing it to the Secretary of Health and Human Services whose street address is:

- We cannot , and will not, require you yo waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosure and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, and about your general condition, or your death.

Communication with family, Food and Drug Administration (FDA), Workers Compensation, Public Health, Abuse and Neglect, Correctional Institutions, Law Enforcement, Health Oversight, Judicial/ Administrative Proceedings, Other uses and Website

I Hereby acknowledge that I have received a copy of this practice's Notice of Privacy practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Sign_____ Date_____

Print Name_____

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to number indicated

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other (Fax/Cell, etc.) _____

_____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify): _____
- ☐ None

_____ _____

Patient Signature Date

_____ _____

Print Name Birth date