# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____

Address _____

Telephone _____ Email _____

Patient _____ Social Security # _____

_____

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 the 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 **Linda Versage** **MARK HERMAN DMD**

Telephone **561-498-0015** Fax **561-496-6336**

Email _____

Address **5329 W. Atlantic Ave. • Delray Beach, FL 33484**

**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.

**SIGNATURE**

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 treatments, payment activities and health care operations.

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: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

*Include completed Consent in the patient's chart.*

Time 8:18 AM | Mark A Herman, DMD, PA | Date 3/27/2018

# Eaglesoft Medical History

Patient Name: (33454) . . Birth Date: Date Created: 3/27/2018

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:_____

TIME 07:48 AM DATE 3/27/2018

# PATIENT REGISTRATION

ID: 33454 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: FL 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: Dr. Mark Herman

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg: Miguel Gonzalez

### Section 3

Emer contact name

Emer contact #

Pt. Pager #

Pt. Cell Phone #

Pharmacy name

Pharmacy #

Physician name

## 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: $0.00 Rem. Deduct: $0.00

## 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: $0.00 Rem. Deduct: $0.00

# MARK A. HERMAN, DMD DBA
# PAYMENT POLICY

IN AN EFFORT TO KEEP FEES REASONABLE AND TO CONTINUE TO PROVIDE QUALITY CARE, WE HAVE ESTABLISHED THE FOLLOWING PAYMENT POLICY.

1. ALL SERVICES THAT INCUR A FEE TO THE PATIENT WILL BE PAID FOR AT THE TIME OF SERVICE. IF THE SERVICE REQUIRES SEVERAL VISITS, WE WILL REQUIRE EITHER PAYMENT IN FULL OR HALF OF TOTAL FEE AT START OF TREATMENT, OPTION OF HALF OR FULL PAYMENT WILL DEPEND ON THE NATURE OF TREATMENT BEING RENDERED. ALL BALANCES WILL BE DUE IN FULL BY THE COMPLETION OF TREATMENT.
2. CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, OR DISCOVER ARE ALL ACCEPTABLE FORMS OF PAYMENT.
3. FOR EXTENSIVE TREATMENT PLANS, WE OFFER A CREDIT PROGRAM WITH "CARE CREDIT", ASK US FOR MORE DETAILS.
4. WE REQUIRE 24 HOUR NOTICE FOR CANCELLATION OF APPOINTMENT. A $45 FEE WILL BE APPLIED FOR "NO SHOW" APPOINTMENTS.
5. THERE WILL BE A FEE TO DUPLICATE X-RAYS IF YOU REQUEST THEM.

WE REQUIRE FULL PAYMENT FOR ALL NON-COVERED SERVICES. DEDUCTIBLES OR CO-PAYMENTS WILL BE COLLECTED AT EACH APPOINTMENT, ALL PATIENTS WILL BE GIVEN A WRITTEN TREATMENT PLAN WHICH ADVISES YOU OF THE TREATMENT THE DENTIST SUGGEST YOU HAVE DONE. WHERE INSURANCE CLAIM FORMS ARE FILED FOR PAYMENT, ALL CHARGES ARE THE PATIENTS RESPONSIBILITY FROM THE DATE THE SERVICE IS RENDERED, WE DO, HOWEVER ACCEPT ASSIGNMENT OF BENEFITS WHEN APPLICABLE.

**WE HAVE A FINANCIAL CONSULTANT WHO WILL BE HAPPY TO HELP YOU WITH YOUR INDIVIDUAL NEEDS.**

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OUTLINES ABOVE I AGREE TO ADHERE TO THIS POLICY.

_____ _____

SIGNATURE OF PATIENT DATE