

AUTHORIZATION TO RELEASE DENTAL RECORDS

In accordance with Florida Statute 456.057 (4) and Board of Dentistry Rule 64B5-17.009, I hereby authorize Dr. _____ to release a photocopy of my dental treatment records and originals or duplicates of any current x-rays to the dental office of:

T. Michael McHenry, D.D.S.,P.A.
214 East Eau Gallie Blvd
Indian Harbour Beach, Fl 32937
(321) 77 SMILE -777-6453

Patient's Name:

Date of Birth:

Patient Signature: _____ Date _____
(Parent or legal guardian must sign if patient is a minor.)

FOR OFFICE USE ONLY

Request sent on _____

Request received on _____

Date Sent: _____

Records and x-rays to be sent: _____



T. Michael McHenry, DDS, PA
214 East Eau Gallie Blvd, Indian Harbour Beach, FL 32937

STATEMENT OF UNDERSTANDING & CONSENT FOR TREATMENT

I certify that the information I have given herein is correct and complete to the best of my knowledge. I agree that if there are any changes to my medical condition, I will inform the dental staff BEFORE any dental treatment is performed. I agree that if any adverse conditions occur as a result of my failure to provide accurate medical conditions and/or updates, I will not hold Dr. McHenry or his staff responsible. I agree to any examinations and x-ray radiographs Dr. McHenry determines necessary for the diagnosis of my dental condition(s). I agree to have any local anesthetics (dental numbing injections) administered as required for my treatment, unless I have an allergy to them. I will be informed by the dental staff of any proposed treatment procedures and will be afforded the opportunity to ask questions before they are performed. Once I agree to treatment, I agree that Dr. McHenry may use any dental materials, laboratories or techniques he deems appropriate for my treatment.

Patient Signature _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

SECTION A:

First Name: _____ M.I.: _____ Last Name: _____

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 our treatment, payment activities, and health care operations. **WE WILL NOT RELEASE ANY OF YOUR HEALTH INFORMATION TO MARKETORS OR SOLICITORS.**

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and health care 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 is available from the Contact Person. 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 our office manager at 321-779-6453 or at the office located at 214 East Eau Gallie Blvd. Indian Harbour Beach, Florida.

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 of the Consent before we receive your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I, _____ (or my personal representative), have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I also agree that my protected health information may also be disclosed to the following person(s): _____

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 _____

Patient
Name: _____

T. Michael McHenry, DDS, PA
214 East Eau Gallie Blvd, Indian Harbour Beach, FL 32937



INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company Name: _____

Insured's Name: _____ Relation to Patient: _____

Group Number: _____ Insured's Policy ID Number: _____

Insured's Date of Birth: _____ Insurance Company Phone: _____

Insured's Employer: _____ Insured's Work Phone: _____

Secondary Dental Insurance

Insurance Company Name: _____

Insured's Name: _____ Relation to Patient: _____

Group Number: _____ Insured's Policy ID Number: _____

Insured's Date of Birth: _____ Insurance Company Phone: _____

Insured's Employer: _____ Insured's Work Phone: _____

OFFICE INSURANCE POLICY AND ASSIGNMENT OF BENEFITS - PLEASE READ CAREFULLY

I understand that an insurance policy is not a guarantee of payment. While every effort will be made to insure the accuracy of my insurance plan benefits, I understand that the office estimate of my insurance benefits is NOT a guarantee of accuracy and in fact will **not be exact**. I understand that a pre-determination of benefits will result in the most accurate estimate of my insurance plan benefits, however even a pre-determination of benefits is NOT a guarantee of payment by the insurance company.

I understand that the office will file for a pre-determination of benefits only on estimated claims exceeding \$500.00 and that a pre-determination of benefits may take in excess of six weeks to be processed by my insurance company. I understand that the filing of my insurance claim is a courtesy extended by the office and that the office is not an agent for my insurance company, and has no control or influence over them, their policies or their payments.

I understand that my insurance company has not examined me and does not know my dental condition and dental needs. I understand that my insurance company may deny payment or change the treatment to a lesser cost treatment option and that this is done strictly for the economic benefit of my insurance company and not to my personal benefit. I understand that my insurance company may not pay for certain materials or procedures and that this is done for the economic benefit of my insurance company and not for my benefit. I understand that Dr. Brown will recommend and use materials and treatment procedures that are in my best interest and not based upon my insurance company's payment considerations.

I agree to be responsible for the full amount of the charges for my treatment.

If I elect to have payment (if any) made to Dr. McHenry by my insurance company, this will be applied towards the full amount of charges for my treatment.

I hereby authorize the release of any information pertaining to my treatment and claim to the above insurance companies and their representatives. I authorize the release of my information to the above insurance companies by electronic submission through national clearing houses that are governed by the HIPPA privacy act.

I hereby authorize payment to be made directly to Dr. Clark Brown of the group insurance benefits otherwise payable to me.

Insured Signature _____ Date _____

Patient
Name: _____

T. Michael McHenry, DDS, PA

214 East Eau Gallie Blvd, Indian Harbour Beach, FL 32937

Office Use
ASA _____



MEDICAL HISTORY

Please list **ALL prescription medications, herbal products and over-the-counter products you are taking**. If you take any "street drugs", please list them. *Any* drug can interact with the medications we administer. Your medical information is private and your health is important.

Do you have or have you had any of the following? (Please circle Yes or No)

Congenital Heart Defect	Yes	No	Rheumatic Fever	Yes	No
Mitral Valve Prolapse	Yes	No	Heart Murmur	Yes	No
Heart Surgery	Yes	No	Joint Replacement	Yes	No
If yes, how long ago? _____			If yes, what type? _____		

Antibiotic Pre-medication

A "YES" answer to any of the above questions may require antibiotic pre-medication or a release from your physician prior to any dental treatment.

If I require antibiotic pre-medication, I understand and agree that it is my responsibility to take the prescribed antibiotics as directed before ANY dental procedure is performed. If I need another prescription for pre-medication, I will ask. I understand that failure to take the antibiotic premedication can result in serious medical complications.

Initial: _____

Asthma or Emphysema	Yes	No	Diabetes	Yes	No
Heart Attack	Yes	No	Pacemaker	Yes	No
Abnormal Bleeding	Yes	No	Hemophilia	Yes	No
Cancer / Chemotherapy	Yes	No	Radiation Therapy	Yes	No
Liver Disease / Hepatitis	Yes	No	Kidney Disease	Yes	No
Epilepsy or Seizures	Yes	No	Stroke	Yes	No
Blood Transfusions	Yes	No	HIV+ or AIDS	Yes	No
High or Low Blood Pressure	Yes	No	Anemia	Yes	No
Alcohol Use (2+ drinks daily)	Yes	No	Tuberculosis (TB)	Yes	No
Tobacco Use	Yes	No	Thyroid Problems	Yes	No
Sinus Problems	Yes	No	Herpes / Fever Blisters	Yes	No

Are you ALLERGIC to any of the following?

Penicillin	Yes	No	Tetracycline	Yes	No	Erythromycin	Yes	No
Sulfa or Sulfides	Yes	No	Aspirin	Yes	No	Codeine	Yes	No
Dental Anesthetics	Yes	No	Jewelry or Metals	Yes	No	Latex	Yes	No

List any other allergies you may have. _____

Are you currently undergoing medical treatment? Yes No What is your current physical health? _____

Please explain any "YES" answer. Also, list any other medical conditions or limitations you have that are not listed above.

I certify that the information I have given on this medical history form is correct and complete to the best of my knowledge. I also understand that complete, correct and up-to-date information is important for my well-being and safety. I understand and agree that it is my responsibility to inform this office of any changes in my medical status before any treatment is rendered.

Patient Signature _____ Date ____/____/____

Patient
Name: _____

T. Michael McHenry, DDS, PA
214 East Eau Gallie Blvd, Indian Harbour Beach, FL 32937



Date: __/__/__

MEDICAL INFORMATION

Medical Doctor Information

Family Physician's Name: _____

Family Physician's Address: _____

City: _____ State: _____ ZIP: _____

Family Physician's Phone: _____ Date of your last visit: _____

Are you under the regular care of a specialist?

Specialist #1

What specialty? _____

What are you being treated for? _____

Specialist's Name: _____

Specialist's Address: _____

City: _____ State: _____ ZIP: _____

Specialist's Phone: _____ Date of your last visit: _____

Specialist #2

What specialty? _____

What are you being treated for? _____

Specialist's Name: _____

Specialist's Address: _____

City: _____ State: _____ ZIP: _____

Specialist's Phone: _____ Date of your last visit: _____

Please list below any other medical professionals whose care you are currently under: