MANATEE FAMILY DENTAL

4012 9TH AVE. W.
BRADENTON, FL 34205
941-749-7638
drsharp@manateefamilydental.com

PATIENT INFORMATION

THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL

DATE ______________

PATIENT'S NAME ______________ (LAST) ______________ (FIRST) AGE ____ BIRTHDATE ______________

IF PATIENT IS MINOR, GUARDIANS' NAME ______________ RELATIONSHIP ______________

RESIDENCE ADDRESS ______________ (STREET) ______________ (CITY) ______ (STATE) ______ (ZIP)

PATIENT [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] SEPARATED [ ] WIDOWED [ ] MINOR [ ] MALE [ ] FEMALE

DRIVER'S LIC. NO. ______________ SOCIAL SECURITY NO. ______________ RES PHONE ( ) ______________

EMPLOYED BY ______________ OCCUPATION ______________

BUSINESS ADDRESS ______________ BUS PHONE ( ) ______________

E-MAIL ADDRESS ______________ CELL PHONE ( ) ______________

SPOUSE'S NAME ______________ DRIVER'S LIC. NO. ______________ SOC. SEC. NO. ______________

BUSINESS ADDRESS ______________ BUS PHONE ( ) ______________

EMERGENCY CONTACT ______________ PHONE NO ( ) ______________

NAME OF PHYSICIAN ______________ PHONE NO ( ) ______________

NAME OF DENTIST ______________ PHONE NO ( ) ______________

WHOM MAY WE THANK FOR REFERRING YOU? ______________

I PREFER TO BE CONTACTED BY:

☐ HOME PHONE ☐ BUSINESS PHONE ☐ CELLULAR PHONE ☐ E-MAIL ☐ PAGER ( ) ______________

BEST TIME TO BE REACHED ______________

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? [ ] YES [ ] NO

DO YOU HAVE SECONDARY DENTAL INSURANCE? [ ] YES [ ] NO

Primary	Secondary
NAME OF INSURANCE COMPANY	NAME OF INSURANCE COMPANY
NAME OF INSURED	NAME OF INSURED
SOCIAL SECURITY NO. / BIRTHDATE	SOCIAL SECURITY NO. / BIRTHDATE
EMPLOYER / GROUP NO.	EMPLOYER / GROUP NO.

CONSENT FOR TREATMENT AND PAYMENT

THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE AND GIVE CONSENT TO PERFORM DENTAL SERVICES AGREED BETWEEN DOCTOR AND PATIENT AND/OR GUARDIAN TO BE NECESSARY OR ADVISABLE INCLUDING THE USE OF LOCAL ANESTHESIA AND OTHER MEDICATION AS INDICATED. I AGREE THAT, REGARDLESS OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.

____

SIGNATURE OF PATIENT / PARENT / GUARDIAN DATE

Manatee Family Dental
Patient Medical History

PATIENT LAST NAME:______________________ FIRST NAME:______________________

DENTAL HISTORY

Reason for today's visit______________________ Date of last dental visit ____________

Former dentist______________________ Date of last dental x-rays ____________

Please check if you have/had:

	Yes	No
Bad breath	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Clench or grind teeth	☐	☐
Growths or sore spots in your mouth	☐	☐
Gums swollen, tender or bleeding	☐	☐

	Yes	No
Head, neck, jaw pain, or aches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐
Orthodontic treatment	☐	☐
Nitrous Oxide	☐	☐
Periodontal treatment	☐	☐
Sensitivity to pressure or irritants (cold, heat, sweets)	☐	☐

How often do you floss? ____________

How often do you brush? ____________

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐Yes ☐No

If Yes, please explain ______________________

Have you ever had trouble from previous dental care? ☐Yes ☐No If Yes, please explain ______________________

MEDICAL HISTORY

Physician's name______________________ Date of last visit __________ Blood Pressure__________

Have you had any serious illnesses or operations Yes ☐ No ☐ If yes, please describe ______________________

Have you ever had a blood transfusion Yes ☐ No ☐ If yes, give approximate dates ______________________

(Women) Are you pregnant? Yes ☐ No ☐ Due date____________ Nursing? Yes ☐ No ☐ Taking birth control pills? Yes ☐ No ☐

Please check if you have/had:

	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required Hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode_	☐	☐
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐

	Yes	No
Headaches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type________	☐	☐
Herpes	☐	☐
High blood pressure	☐	☐
Any immune deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker	☐	☐
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐

	Yes	No
Slow healing wounds	☐	☐
Stroke	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsilitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐
Are you currently under the care of a Physician?	☐	☐
Are you allergic/sensitive to Latex?	☐	☐
Allergic to Penicillin, Aspirin, or other drugs?	☐	☐

If Yes, please specify ______________________

List any medications that you are taking:

____

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature______________________ Date______________

Reviewed by:______________________ Date ______________

MANATEE FAMILY DENTAL

OFFICE PROCEDURES OF AMANDA SHARP N. SHARP, D.D.S.

1. It is our office procedure that we will address you by your first or last name.
2. Phone/Text/Email Confirmation: It is our office procedure that we call to confirm your appointment. It is also our procedure that you call 24 hours prior to your appointment to cancel your appointments. We may also call our regarding medical & financial issues. May we contact you by:
   Call: Y / N **Text:** Y / N **Call & Text:** Y / N **Email:** Y / N
   May we leave a message on your answering machine: Y / N
3. Verbal Authorization: It is our office procedure to get verbal authorization from all new patients to confirm appointments and leave messages. Also patients must call/text/email us 24 hours in advance to cancel any appointments.
4. Photo & Video Examinations: it is our office procedure to take photos/videos of your face, mouth, and teeth which is stored in your chart.
5. It is our office procedure to share Protected Health Information with labs, consulting dentists, physicals and hospitals. We will also contact the pharmacy of your choice. We will only exchange minimum necessary Protected Health Information for each transaction.
6. Our office is HIPPA compliant and the staff has been trained in the HIPPA Privacy Act. We will do everything we can to protect your Patient Health Information. However, our office was designed before the HIPPA Law so please be respectful of other patient's privacy.

I, ______________________________ agree to all of the above office procedures of Amanda N. Sharp, D.D.S. and give my authorization to all of the above.

______________________________ ____________________

Patient Signature *Date*

List name of minor family member(s) we are authorized to contact you about and their ages:

______________________________ __________

______________________________ __________

______________________________ __________

______________________________ __________

I, ______________________________ authorize Amanda N. Sharp D.D.S. to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Amanda N. Sharp D.D.S. I authorize Amanda N. Sharp D.D.S. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all the rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray, consulting physicians and hospitals. We will contact the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

______________________________ ____________________

Patient Responsible Party Signature *Date*

Notice of Privacy Practices
Manatee Family Dental

Manatee Family Dental is required, by law, to maintain the privacy and confidentiality of our patients' protected health information. We take this duty very seriously. We are also bound by law to provide our patients with notice of our legal duties and privacy practices with respect to their protected health information. That is part of the purpose of this notice.

Disclosure of Patient Health Care Information

- In connection with treatment, we may disclose patient health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
- We may disclose patient health information to insurance providers for the purpose of payment or health care operations.
- We may disclose patient health information as necessary to comply with State Workers' Compensation Laws.
- We may disclose patient health information to notify or assist in notifying a family member, or another person responsible for patient care about patient medical condition or in the event of an emergency.
- As required by law, we may disclose patient health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
- We may disclose patient health information in the course of any administrative or judicial proceeding.
- We may disclose patient health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- We may disclose patient health information to coroners or medical examiners.
- We may disclose patient health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- We may disclose patient health information to researchers conducting research that has been approved by an Institutional Review Board.
- It may be necessary to disclose patient health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
- We may disclose patient health information for military, national security, prisoner and government benefits purposes. In the event that Manatee Family Dental is sold or merged with another organization, patient health information/record will become the property of the new owner.

Patient Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your or your child's patient health information. Please be advised, however, that Manatee Family Dental is not required to agree to the restriction that you requested.

- You have the right to have your or your child's health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon request.
- You have the right to inspect and copy your or your child's patient health information.
- You have a right to request Manatee Family Dental amend your or your child's protected health information. Please be advised, however, that Manatee Family Dental is not required to agree to amend patient protected health information. If your request to amend patient health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your or your child's protected health information made by Manatee Family Dental.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.
- Manatee Family Dental reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Manatee Family Dental is required by law to comply with this Notice.
- If you have questions about any part of this notice or if you want more information about patient privacy rights, please contact: Dr. Sharp by calling this office at 941-749-7638. If Dr. Sharp is not available, you may make an appointment for a personal conference in person or by telephone.
- If you wish, you may submit a formal complaint to:

DHHS
Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH
Building Washington,
DC 20201

Please sign and date that you have read and understood this privacy notice.

____________________	____________________	____________________
Patient or guardian signature	Relationship to patient	Date

Please list below any person that we may disclose any pertinent dental/health information to (family member, spouse):

____________________	____________________
Name	Relationship to patient
____________________	____________________
Name	Relationship to patient

Adult Sleep & Breathing Questionnaire

Date: ______________________________

Patient 's Name: ______________________________

Patient's Date of Birth: ______________________ Age: __________

Male ______ Female ______

Have you ever had a sleep test administered? ______yes ______no

If yes - when did you have your last sleep test? ______________________

Have you been diagnosed with Sleep Apnea? ______yes ______no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? ______yes ______no

Are you happy with your CPAP or Sleep Appliance? ______yes ______no

If you are not happy - why? ______________________________

____

____

How often do you get out of bed to use the restroom during the night? __________

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosted with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches}}$