Manatee Family Dental

This information is necessary for our files only and will be confidential

Name _____ Birthdate _____/_____/_____
Last First Middle

If Minor, Guardian's Name _____ Relationship _____

Address_____ City _____ State_____ Zip_____

Patient [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ] Minor [ ] Male [ ] Female

Home # (_____) _____ Cell # (_____) _____ Work #(_____)_____

Driver's Lic. #_____ State _____ SS #_____

Email Address_____

Employer_____ Occupation_____

Spouse/SO Name _____ Cell # (_____)_____

Emergency Contact_____ Cell # (_____)_____
Name Relationship to Patient

Whom may we thank for your referral? _____

Dental Insurance Information:

Primary Dental Insurance Company _____ Phone # (_____)_____

Primary Subscriber Name _____ Relationship_____ DOB ____/_____/____

Dependent Name _____ Relationship_____ DOB ____/_____/____

Subscriber ID #_____ Group # _____

***Cancellations*:** When you schedule an appointment with our practice, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Effective April 1, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a **24 Hour notice** will be considered a No Show and charged a **$50.00 Fee.**

Phone/Text/Email Confirmation: It is our office policy that we call to confirm your appointment. It is also our policy that you call 24 hours prior to your appointment to cancel your appointments. We may also call you regarding medical & financial issues. May we contact you by: **Call:** Y / N **Text:** Y / N **Email:** Y /N Allow Voicemails: Y / N

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 medications as indicated. I agree that regardless of insurance coverage, I am responsible or payment of services rendered.

_____ _____/_____/_____
Patient Signature Date

* 4012 9th Avenue West Bradenton Florida 34205 * Office (941)749-7638 Fax (941)751-9812 * drsharp@manateefamilydental.com *

Name_____
First Middle Last

Manatee Family Dental

Reason for visit _____

Former Dentist _____ Last dental exam/cleaning _____/_____/_____

How often do you floss? _____ How often do you brush _____

Please check if you have/had:

- □ Cold sores/fever blisters/herpes
- □ Dry mouth
- □ Food collection between teeth
- □ Clench/grind teeth
- □ Gums swollen, tender or bleeding
- □ Head, neck, jaw pain or aches
- □ Lip or cheek biting
- □ Loose teeth or broken fillings
- □ Mouth breathing
- □ Orthodontic treatment
- □ Periodontal treatment
- □ Sensitivity to hot, cold or sweets

Medical History

Physician's Name_____ Office # (_____) _____ Date of Exam ____/____/____

Allergies: Penicillin Aspirin Codeine Sulfa Tetracycline Latex Local Anesthetic Other: _____

Please list all of your medications: _____

_____

Please check if you have/had:

- □ Heart problems, or cardiac stent within the last six months Date ____/____/____
- □ History of infective endocarditis
- □ Artificial heart valve, repaired heart defect (PFO)
- □ Heart murmur
- □ Heart attack Date___/_____/____
- □ Stroke Date ____/_____/_____
- □ Pacemaker Placed ___/____/___
- □ Anemia or other blood disorders
- □ High or Low blood pressure
- □ Circulatory problems
- □ Prolonged bleeding due to cut (INR>3.5)
- □ Arthritis, rheumatoid arthritis, lupus
- □ Allergies, hay fever, sinusitis
- □ Asthma
- □ Cough, persistent or bloody
- □ Tuberculosis
- □ Emphysema/shortness of breath
- □ Thyroid, parathyroid disease or calcium deficiency
- □ Hormone deficiency
- □ High cholesterol or taking statin drugs
- □ Diabetes: Type I II
- □ Glaucoma
- □ Epilepsy, convulsions (seizures)
- □ Digestive disorders (i.e. celiac disease, gastric reflux)
- □ Stomach or duodenal ulcer
- □ Kidney disease
- □ Jaundice/ Liver disease
- □ HIV/AIDS
- □ STI/STD
- □ Hepatitis A B C
- □ Mitral valve prolapse
- □ Artificial joints Location_____ Year _____
- □ Do you premedicate for dental appointments? If so, what do you take & why_____
  _____
- □ Osteoporosis/osteopenia
- □ History of bisphosphonates. If so, do you take Fosamax, Boniva, Prolia, Actonel, Reclast, Zometa
- □ Cancer: Type _____ Year _____
  Type of Treatment: Chemotherapy or radiation. If so, Date/Location_____
  _____
- □ Alcohol: Daily - Weekly - Monthly Intake
- □ Smoking or smokeless tobacco: _____pack per day

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 POLICIES OF AMANDA N. SHARP, D.D.S.

1. It is our office policy that we will address you by your first or last name.
2. ***Verbal Authorization***: It is our office policy 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.
3. ***Photo & Video Examinations***: It is our office policy to take photos/videos of your face, mouth, and teeth which is stored in your chart. We may take the photography or it may be taken by a designee approved by my healthcare provider. The photography shall be used for medical records and if, in the judgement of my healthcare provider, medical research, education or science will be benefited by its use, such photography and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he/she may deem proper in the interest of medical education, knowledge and research. It is specifically understood that in any such publication or use, all reasonable effort will be made so that I shall not be identified by name. I understand I may be recognized and identifiable in the photography. All reasonable efforts will be made to avoid personal identification.
4. It is our office policy 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.
5. 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 policies of Amanda N. Sharp, D.D.S. and give my authorization to all of the above. 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*

Manatee Family Dental

Notice of Privacy Practices

Manatee Family Dental is required by law to maintain the privacy and comfort in geology of our patients protected health information. We take this duty very seriously. We are also bound by law to provide our patients with 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 healthcare 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 healthcare operations.
- We may disclose patient of health information is necessary to comply with state Worker's Compensation laws.
- We may disclose patient health information to notify or assist in a 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 purpose related to: preventing or controlling disease, injury or disability, report child abuse or neglect, report domestic violence, reporting of the food and drug administration problems with products and reactions to medications, and reporting disease and 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 corners or medical examiners.
- We may disclose patient health information to organizations involved and procuring, banking, or transplanting organs and tissue.
- We may disclose patient health information to researchers conducted 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 adamant threat to the health or safety of a particular person or the general public.

- We may disclose patient health information for military, national security, prisoner or 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 you or your child's patient health information. Please be advised, however, that Manatee Family Dental is not required to agree to the restriction of that request.
- 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 your request.
- You have the right to inspect and copy you or your child's patient health information.
- You have a right to request Manatee Family Dental amend you or your child's protected health information. Please be advised, however, that Manatee Family Dental is not required to agree to amend patient's protected information. If you are a request to amend patient health information has been denied, you'll be provided with an explanation of our denial reason(s) and the information about how you can disagree with the denial. You have the right to receive and accounting of disclosures of you or your child protected health information made by Manatee Family Dental.
- You have the right to a paper copy of this notice of privacy practices at any time upon your 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 affective 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 any 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 of Civil Rights
  200 Independence Ave, S.W.
  Room 509F HHH Building
  Washington, DC 20201

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

Patient/Guardian _____ Date _____/_____/_____

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

Name _____ Relationship_____

Name _____ Relationship_____

Sleep Apnea Questionnaire

Manatee Family Dental

Name _____ Date _____/_____/_____

Age _____ Height _____ Weight _____

Have you ever had a sleep test administered? Yes / No

If yes, when was your last sleep test Date ____/____/____

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

Do you have blocked nasal passages? Yes / No

Do you ever wake up choking or gasping? Yes / No

Do you grind your teeth while sleeping? Yes / No

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
Do you often feel TIRED, fatigued, or sleep during daytime?	YES	NO
Has anyone OBSERVED you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood PRESSURE?	YES	NO

BANG		
BMI greater than 35?	YES	NO
AGE over 50 years old?	YES	NO
NECK circumference > 16 inches (40cm)?	YES	NO
Gender	Male	Female

TOTAL SCORE

High risk of OSA: Yes (5-8)

Intermediate risk of OSA: Yes (3-4)

Low risk of OSA: Yes (0-2)