MANDARIN

DENTISTRY

11518 SAN JOSE BOULEVARD
JACKSONVILLE, FLORIDA 32223
Telephone (904) 268-5600

Welcome to our office. We appreciate the opportunity to provide you with dental services. This letter is to introduce you to our staff and policies and to help answer many questions about our office.

Our office focus is preventive and restorative dental care. It is our intention to provide this care in a comfortable manner using the most up-to-date techniques. We hope that you share in our belief that regular check-ups and cleanings are an important step in preventing serious dental problems. You will be notified by mail or phone when it is time for your check-up.

We see patients on an appointment only basis. We make every effort to honor time commitments and scheduling preferences. If you cannot keep a scheduled appointment, please notify the office within 24 hours. We also understand that dental emergencies arise from time to time. We will do our best to take care of your problems in a timely manner.

If you have dental insurance, we will be happy to submit it for you. Please be aware that dental insurance typically does not cover the full cost of your treatment and our fees are not based on what the insurance company may allow. It is the responsibility of the patient to pay any deductible coinsurance or any balance not paid by the insurance company, at the time of your visit. We will be glad to answer any questions you may have regarding your coverage.

Everyone in this practice is a team member. All have been highly trained as professionals and we take great pride in our capability. We attend continuing education courses on a regular basis to stay current with new techniques and concepts in dentistry. We are here to serve your dental needs, so please do not hesitate to call upon us when the need arises.

Enclosed you will find a registration and health history form. It is important that we know your dental and medical history before treating you. All of your information remains confidential Thank you for your confidence in choosing us as your dental healthcare team.

Sincerely,
Megan Moshea, D.D.S. and Staff

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Patient Registration

Today's Date _____

Last Name _____ First Name _____ MI ___ Date of Birth _____ Age ___

Sex M or F Soc. Sec.# _____ Please Circle One: Single Married Separated Widow

Mailing Address _____ City _____ State _____ Zip Code _____

Email _____ Home Phone (____) _____ Cell Phone (____) _____

Driver's License # _____ Employer _____

WorkPhone (____) _____ Occupation _____

Are you a full time student? Yes or No If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____ Parent Soc. Sec.#_____

Parent Employer _____ Parent Phone (____) _____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone# (____) _____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us?

☐ In-home Mailer ☐ Social Media ☐ Insurance ☐ Practice Website ☐ Internet ☐ Family/ Friend/Coworker

☐ Other _____ *Who can we thank for your visit?* _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental Insurance Information (Secondary Coverage)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance ID # _____ Group # _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ WhiterTeeth

Please share the following dates:

Your last cleaning ____/____ Your last oral cancer screening ____/____ Your last complete X-rays ____/____

What is the most important thing to you about your future smile and dental health? _____

_____

Dental History Cont. Please mark (x) any of the following conditions that apply to you

Patient Name (print) _____

Appearance
- ☐ Discolored teeth
- ☐ Worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Spaces
- ☐ Overbite
- ☐ Flat teeth

Pain/Discomfort
- ☐ Sensitivity (hot, cold, sweet)
- ☐ Pressure
- ☐ Broken teeth/fillings
- ☐ Worn teeth
- ☐ Dry Mouth

Function
- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ) pain
- ☐ Jaw Joint (TMJ) clicking/popping
- ☐ Bad Bite
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Sore Muscles (neck, shoulders)
- ☐ Difficulty Opening or Closing
- ☐ Difficulty Chewing on either side

Periodontal (Gum) Health
- ☐ Bleeding, Swollen, Irritated gums
- ☐ Bad breath
- ☐ Loose tipped, shifting teeth
- ☐ Previous perio/gum disease

Habits
- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/Lip biting
- ☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Bed wetting (for children)

Social
Tobacco

How much _____ How long _____

Alcohol Frequency _____

Drugs Frequency _____

Previous Comfort Options
- ☐ Nitrous Oxide
- ☐ Oral Sedation (Pill)
- ☐ IV Sedation

Please list family history of any conditions marked:

_____

_____

_____

_____

_____

_____

_____

Medical History Please mark (x) to your response to indicate if you have or have had any of the following

Cancer
Type _____
- ☐ Chemotherapy
- ☐ Radiation Therapy

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Artificial Heart Valve
- ☐ Heart Conditions
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Gastrointestinal
- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easily
- ☐ Excessive Bleeding

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Illness

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV

Women
- ☐ Currently Pregnant
- ☐ Nursing

Medical Allergies
- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local Anesthetics
- ☐ NSAIDs

Other Allergies
- ☐ _____

Additional Comments:
_____

_____

_____

Are you under the care of a physician? If yes, please explain _____

_____

Physician Name _____ Address _____ Phone# (____) _____

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N. If yes please explain _____

_____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements_____

_____

_____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If yes, please list medications _____

Have you ever had surgery? If yes, what type _____

_____

Consent:
The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____ _____

Signature of Patient/Legal guardian *Print Name* *Date* *Dentist Signature*

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DENTISTRY

Patient Name (print) _____

Acknowledgement Of Receipt Of Notice Of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____
Patient Name (Printed)

_____
Signature

_____
Date

Authorization To Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____ , authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
Name (Printed) *Relationship*

_____ _____
Name (Printed) *Relationship*

_____ _____
Name (Printed) *Relationship*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other *(Please Specify)*

_____

_____

_____

MANDARIN
DENTISTRY

Financial Policy

Patient Name (print) _____

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options. ☐

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide, including calls to mobile/cellular or similar devices, for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent, if child) Date

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DENTISTRY

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, Mandarin Dentistry will transmit my prescriptions electronically as permitted, to the pharmacy that I delegate as my primary pharmacy provider. Additionally, Mandarin Dentistry will obtain the history of all of my past prescriptions and I understand that those prescriptions will become a part of my electronic health record. E-Prescribing greatly reduces medication errors and enhances patient safety.

Features of our ePrescribe program include:

- Formulary and benefit transactions — Provides us with information about which drugs are covered by the drug benefit plan.
- Medication history transactions — Provides us with information about medications you are already taking.
- Fill status notification- Sends us an electronic notice that your prescription has been picked up.

By signing this consent form you are agreeing that we can ePrescribe for you and request your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

☐ I hereby provide informed consent to enroll me in the ePrescribe program.
☐ I decline this option. I do not give permission for access to the above information.

Pharmacy Information

Pharmacy Name _____

Address _____

Phone # _____

_____ _____

Signature of Patient or Legal Representative Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN ACCESS YOUR INFORMATION. PLEASE READ IT CAREFULLY.

ABOUT THIS NOTICE

This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" includes demographic information, that may identify you and relates to your past, present, or future physical or mental health condition and related health care services including dental care.

This Notice takes effect **2-8-2022.** We reserve the right make updates. Updated Notices will be available in our office as well as on our website.

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. To obtain a copy please contact the office or visit our website at ***www.mandarindentistry.com***

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of our practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to another provider to whom you have been referred so they have the necessary information to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your services. For example, filing for insurance benefits as applicable for our practice.

Healthcare Operations: We may use or disclose your protected health information as needed, in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, training of interns, licensing, billing services, and other business activities. We may also use a sign-in sheet, call you by name in the waiting room, send appointment reminders via phone, email, or text, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may take intra oral and facial photos for treatment-related purposes. If we use or disclose your PHI for fundraising activities, we will provide you the choice to opt out. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. We will make disclosures to you upon your request.

Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law. We may disclose your PHI to a personal representative, such as a spouse, relative, or caretaker involved in your care related to their involvement in your treatment or payment of services providing you identify these individual(s) and authorize the release of information. If a young adult age of legal age requests that their information not be released to a parent or guardian, we must comply with this request.

Without your authorization, we are expressly prohibited from using or disclosing your PHI for marketing, fundraising, or research purposes. We may not sell your PHI without your authorization. You may revoke these authorizations, at any time, in writing, except to the extent that we have already taken an action based upon your prior authorization.

YOUR RIGHTS

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your PHI whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, PHI restricted by law, information that is related to research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your requested restriction except if you request that we not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – This request must be made in writing and we have 30-days to reply. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. We may deny amending your PHI if we did not create the information or if the treating provider who created the information is no longer available to make the amendment.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting (listing) of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We would notify you if your unsecured PHI held by our practice or a business associate has been breached. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable, and undecipherable to unauthorized users.

You have the right to obtain a paper copy of this Notice from us even if you have agreed to receive the Notice electronically. We will also make available copies of our new Notice if you wish to obtain one.

We reserve the right to change the terms of this Notice. The new Notice will be available upon request, posted in our office, and on our website.

COMPLAINTS

You may file a complaint with us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

If you have any questions or wish to file a complaint, please contact us at:

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904-268-5600

U.S. Department of Health & Human Services
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