Palm Family Dental

704 Palm Blvd. N. Niceville, Fl. 32578

850-678-2184 fax 850-678-4910

We would like to take this opportunity to welcome you to our office. We consider it a privilege to serve you and look forward to your first visit.

Enclosed is a health history form for you to fill out and returned to our office **before** we schedule your first appointment. Also enclosed is a record release form to send to your previous dentist for any current x-rays. If you would like us to fax the form to your previous dentist, we will need the email address and or fax number to send for your x-rays. **The x-rays and health history needs to be in our office before we schedule your first appointment.**

Palm Family Dental

Child's Name: _____ Birthdate: _____

PEDODONTIC DENTAL HISTORY

1. Is this visit for emergency treatment only or is it for a routine complete exam (chief complaint?) _____ Yes No
2. Has your child been treated by a physician recently? Yes No
   If so, what for? Give name of physician. _____
3. Does your child take any medicines? Yes No
   If so, what kind? _____
4. Does your child have allergies to drugs, food, etc.? Yes No
   If so, what kind? _____
5. Does you child have any emotional, mental, physical, or nervous disorder? Yes No
6. Has your child ever had any problems with any of the following: (Underline)

   heart kidney diabetes asthma liver T.B. anemia
   epilepsy rheumatic fever school speech bleeding
   cleft palate frequent colds hepatitis aids

7. What is your primary concern about your child's dental health _____
8. Is this your child's first visit to the dentist? Yes No
   If no, what was done previously (restoration, extractions, space maintainers, etc.) _____
9. Has your child ever had a toothache? Yes No
   If yes, when? (1) while eating _____ (2) at night _____
   (3) spontaneous _____ (4) persistent _____
   How long ago _____
10. Has your child ever bumped his teeth? Yes No
11. Does your child have crooked teeth? Yes No
12. Does your child suck his thumb or finger or does he have any similar habits? Yes No
13. Will your child be an uncooperative patient? Yes No
    If yes, explain. _____
14. Is there anything special you would like the doctor to know about your child? Yes No
    If yes, explain _____
15. Child's favorite name: _____
16. Child's hobbies if any: _____
17. Are there any questions you would like Dr. Mihalcik to answer _____

Father	Mother
Name	Name
Home Address	Home Address (if different)
Home Phone	Home Phone (if different)
SS #	SS #
Business Address & Co.	Business Address & Co.
Office Phone	Office Phone
Dental Ins. Co. & Policy	Dental Ins. Co. & Policy

THANK YOU for your cooperation in filling out this form.

If this is your initial exam please sign and date. I understand that a monthly interest charge of 1.5% will be charged to my unpaid balance if that balance is not paid within 30 days.

Signature: _____ Date: _____

Please review and update the health history on the reverse side of this form. Also please sign and date below so we know the date of your last update. Thank you.

Signature:	Date:

I authorize **Palm Family Dental** to bill and receive payment from my dental/medical insurer for services performed on myself or on any child for whom I am the legal guardian.

Signed _____

I authorize **Palm Family Dental** to use any oral images of my teeth taken in his office for educational purposes.

Signed _____

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

(Initial below)

I _____ DO AGREE

I_____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

____Text Messaging

____ Email

I would like to receive:

____ Appointment Reminders/Recall Visits

____ Information regarding insurance/billing

____ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at anytime by calling:

INSERT YOUR OFFICE NAME|PHONE NUMBER|OFFICE EMAIL ADDRESS:

Patient Signature:_____ Date:_____

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

   _____
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.
8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement***

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

_____
Please Print Name

_____
Signature

_____
Date

_____
For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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)

_____

_____

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X-ray & Record Release

Please release my x-ray/records to:

Email: palmfamilydental@mmihalcik.com

Please list previous
Dental Practice, email & phone number

_____

_____

_____

List all family members & DOB's associated
with this record release

_____

_____

_____

_____

_____

Authorized signature Date:

_____

Palm Family Dental

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** effective as of July 1, 2023. This allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follow:

We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the **Appointment Cancellation Policy** and I agree to its terms. I also understand and agree that such terms may be amended from time -to- time by the practice. Due to the number of new residents we provide service to and wait list for our local community.

I, _____ (print name). Have received a copy of

Palm Family Dental Appointment Cancellation Policy.

_____ _____

(Signature of Patient) (Date)

DENTAL TREATMENT CONSENT FORM

Dentist's Name *Palm Family Dental* Patient's Name:_____

Please read and initial the items checked below and read and sign at the bottom of form.

☐ **1. X-RAYS** (Initials_____)

☐ **2. DRUGS AND MEDICATIONS**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____)

☐ **3. CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

☐ **4. REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
(Initials_____)

☐ **5. CROWNS, BRIDGES AND CAPS**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.
(Initials_____)

☐ **6. DENTURES, COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
(Initials_____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initials_____)

☐ **8. PERIODONTAL LOSS (TISSUE & BONE)**
I understand that care must be exercised in chewing on fillings especially during the first 24 months to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials_____)

☐ **9. FILLINGS**
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filing. (Initials_____)

☐ **10. DENTURES**
I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. (Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent/Guardian if patient is a minor_____ Date_____