

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.**

Your Health Your Concern and Ours

PALM FAMILY DENTAL

In this office, your health is of vital concern to us. We have long known that the health of the mouth cannot be separated from the health of the rest of the body. By your presence here you show your interest in an overall program of health and well being. With the following information we can make a scientific analysis of your dental examination and be able to serve you in our particular areas, namely; appearance, comfort, ability to chew, digest and enjoy food, and the detection, elimination, and prevention of dangerous diseases and infections of the mouth.

Name: _____ Birth date: _____
 Address: _____ Occupation: _____
 City: _____ Zip Code: _____ Email: _____
 Is this visit for emergency treatment only or is it for a routine complete exam (list chief complaint)? _____

Are you subject to frequent cavities? _____ How often do you brush your teeth? _____
 Are your teeth sensitive to pressure? _____ sweets? _____ heat? _____ cold? _____
 Are your gums tender or swollen; do they bleed? _____
 Have you ever been treated for any gum disease? _____
 Are you aware of bad taste or odor? _____
 Do you grit or grind your teeth during the day? _____ night? _____ period of stress? _____
 Do your jaws get tired after eating? _____ Do your jaws pop? _____
 Do you chew on both sides of your mouth? _____ Are you satisfied with the appearance of your teeth and/or their function? _____
 Do you desire to save your teeth if possible? _____ Date of last dental visit: _____
 Were x-rays taken? _____ Have you had any serious trouble associated with any previous dental treatment? _____
 Have you ever had Oral Hygiene Instruction? _____ Have any missing teeth been replaced? _____
 If so, what type of replacement was used? _____
 Are you calm or apprehensive about dental visits? _____
 If there are any questions you would like Drs. Mihalcik or Nohalty to answer or if there is anything else you think they should know about your medical history, please list. _____

Whom may we thank for referring you to this dental office? _____
 After completion of treatment, do you wish the preventive services this office provides by recalling our regular patients for check ups at six month intervals? _____

<i>PRESENTLY UNDER CARE OF PHYSICIAN</i>	YES	NO	VENEREAL DISEASE	YES	NO
MEDICAL DIAGNOSIS:			LIVER OR KIDNEY TROUBLE		
RECENT ILLNESS			OSTEOPOROSIS MEDS (FOSAMAX, BONIVA?)		
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:			CHEMOTHERAPY OR RADIATION TREATMENT		
ANY ALLERGIES OR SENSITIVITIES			HIGH BLOOD PRESSURE		
TOOTH EXTRACTION - DIFFICULTY			TUBERCULOSIS		
PROLONGED BLEEDING FROM CUTS, ETC.			(A.I.D.S.) ACQUIRED IMMUNE DEFICIENCY SYNDROME		
ILL EFFECTS FROM INJECTIONS OF NOVOCAIN OR XYLOCAINE			HEART DISEASE/RHEUMATIC FEVER/MURMUR		
DIABETES			RECEIVING MEDICATION		
CONVULSIONS OR DIZZY SPELLS			WOMEN: ARE YOU PREGNANT?		
HEPATITIS			ANY MEDICAL CONDITION NOT MENTIONED		
REMARKS					

LIST OF MEDICATIONS:	

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: _____

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CLIENT RIGHTS AND HIPAA AUTHORIZATIONS
(Page 2 of 2)

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 may 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.

MICHAEL J. MIHALCIK, D.M.D., P.A.

**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 & Records Release

Please release my x-ray/records to:

Email: xray@NicevillePalmFamilyDental.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 filling. (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 relining 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 _____



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Dental Insurance Policy Information:

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder Social Security Number: _____ -- _____ -- _____

Insurance Company: _____

Insurance Company Address: _____

Group Number: _____

Do you have dual Coverage? YES NO

Policy Holder name for Secondary Policy: _____