Jeremy Gerber, D.M.D., P.A.

WELCOMES YOU **Date**__________

First Name________________________ Last Name______________________ M.I.__________

Home Address____

City____________________________ State_____ ZIP__________ Date of Birth____________

Home Phone_____________________________ Cell Phone______________________________

Age:________ Sex: Female or Male Marital Status: Single, Married, Divorced, Separated, Widowed

Social Security Number__________________________ Dr Lic#___________________________

Email Address____

Employed by______________________________ Business Phone__________________________

Business Address____

Person to call in case of emergency: Name__________________ Relationship________________

Phone____________________ Name of person referring you or advertising method____________

GENERAL HEALTH QUESTIONS

1. Do you have or have you had any of the following? Please **CIRCLE** the condition:

Heart Attack/Heart Trouble	Thyroid Disease	Open Heart Surgery
Mitral Valve Prolapse	High Cholesterol	Heart Valve Replacement
Congenital Heart Disease	Arthritis/Night Sweats	Nervous Disorder
Anemia/Blood Disorders	Diabetes/Fainting Spells	Asthma/Emphysema
Rheumatic Fever/Heart Murmur	Migraine Headaches	Glaucoma/Tumors
Blood Pressure (High or Low)	Cancer Treatment	Hepatitis/Liver Disorders
Stroke/Kidney Disease	Radiation Treatment	Herpes Virus
Extreme Weight Loss/Anorexia	Epilepsy/Seizures	Tuberculosis/Blood Sputum
Ulcers/Prostate Problems	HIV Positive/Venereal Disease	Persistent Cough
Allergic to Metals	TMJ Problems	Knee/Joint Replacements
Periodontal Surgery	Pacemaker/Palpitations	Pregnancy # of Months_____

Initials/Date of Doctor Reviewing Medical History______________

2. Are you under the care of a physician at this time? YES NO
   If yes, why?____
3. Are you taking any drugs or medications? (Blood thinners/ Aspirin?) YES NO
   If yes, name and dosage________________________________
4. Are you allergic or have you reacted adversely to any medication, food,
   Or anesthetic? If yes, name_____________________________ YES NO
5. Do you have any bleeding/clotting problems, blood transfusions? YES NO
6. Do you have any joint replacements? YES NO
7. Do you usually heal quickly? YES NO
8. Do you smoke? YES NO
9. Have you ever been hospitalized? YES NO
   If yes, why?____
10. Anything not listed above________________________________

DENTAL HEALTH QUESTIONS

Why are you here today? ______________________________ Emergency ______

Have you ever had any teeth extracted? ______________________________

Are you interested in replacing missing teeth? Implants____ Dentures____ Crowns____ Bridges____

Are your teeth sensitive to: Heat____ Cold____ Sweets ____

Does food catch between your teeth? ________ Do your gums bleed when you brush? ________

Have you noticed any gum swelling around your teeth? ________ Teeth shifting or mobility________

Are you satisfied with your teeth/gums and their appearance? ______________

Have you noticed any: Unpleasant odor________ Unpleasant taste ________

When was your last dental appointment? ______________ Last cleaning date______________

Why did you leave your last dentist? ______________________________

FINANCIAL ARRANGEMENTS

Method of payment for treatment: Credit Card____ Cash____ Check____ Carecredit ____ Insurance____
Payment is due in full at the time of services unless other arrangements have been made and authorized by office personnel. Use of credit card authorizes Jeremy Gerber DMD, PA payment in full on dental balances with signatures on file.

DENTAL INSURANCE INFORMATION

Name of Insurance Company______________________ Plan Name______________

Name of Primary Subscriber______________________ Social Security #__________

Primary's Birthdate ______________ Relationship to Patient ______________

Note: The doctor will select a treatment plan that best suits your needs. You will be informed of all the alternative treatments available to you. Please do not ask the doctor to provide the "free" benefits and neglect treatment which is in the best interest of the patient. The dentist has the right to request you transfer out of the office, rather than supervise your own dental neglect. As insurance co-payments are an <u>estimate,</u> balances remaining are the patient's responsibility.

Authorization and Release: I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.

PATIENT NAME: ______________ SIGNATURE: ______________ DATE: ________

WITNESS NAME: ______________ SIGNATURE: ______________ DATE: ________

Jeremy Gerber DMD PA
Notice Of Privacy Practices-Short Form

Our practice is committed to educating our patients about healthcare issues that affect them. As a result we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPAA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patients personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patients of our practice and we are require by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?

Any health information you provide our practice, including your mailing address. IIH is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligation concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our waiting room and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Appointment Remainders	Release of Information to Family/Friends
Payment	Treatment Options	Disclosures Required by Law
Health Care Operations	Health-Related Benefits and Services	

The Following Categories describe the different way which we may use and disclose your identifiable health information:

Public Health Risks	Health Oversight Activities	Lawsuits and Similar Proceedings	Law Enforcement
Deceased Patients	Organ and Tissue Donation	Serious Threats to Health or safety	Research
Military	National Security Inmates	Workers Compensation	

What are your rights concerning your individually identifiable Health Information (IIHI)?

You have right regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communication
2. Requesting Restrictions
3. Inspection and copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper Copy of this Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

* If you have any question regarding this notice or our health information privacy, please contact:

Jeremy Gerber DMD
1332 Se 17th street
Ft. Lauderdale, Fl 33316
(954) 763-4403

Signature　　　Print Name of Patient　　　Date