Soni Smiles
GENERAL & IMPLANT DENTISTRY

Soni Smiles General and Implant Dentistry
1511 Lakeview Rd. Clearwater, FL 33756
727-441-1571

New Patient Information

Name: _____

Address: _____

SS #: _____ DOB: _____

□ Male □ Female □ Single □ Married □ Other

Email: _____ Driver's License: _____

Home Phone: _____ Work: _____ Cell: _____

Responsible Party: □ Self □ Guardian/Other (Please complete information below)

Name: _____ Relation: _____ Phone: _____

EMERGENCY CONTACT: _____ _____
Name Phone

_____
Relation to Patient

The office of **Ravi Soni, DMD** , has consent to speak with the above named person regarding dental treatment and/or account information. Patient Signature: _____

Are you experiencing a dental emergency? □ NO □ YES If yes, please explain: _____

Last dental cleaning: _____ Last dental exam: _____

Previous Dentist: _____

REFERRAL INFORMATION:

Whom may we thank for referring you?

□ Internet / Google □ Insurance Provider □ Person: _____

□ Print Ad (Newspaper, etc.) □ Postcard □ Other: _____

INSURANCE INFORMATION:

Policy Holder's Information:

Name: _____ Relation: _____

Birth Date: __ __ / __ __ / __ __ __ __ Employer: _____

Social Security Number: _____

Insurance Company: _____ Insurance Phone Number: _____

Address on Back of card: _____ Member ID: _____

_____ Group No.: _____

Soni Smiles
GENERAL & IMPLANT DENTISTRY

Soni Smiles General and Implant Dentistry
1511 Lakeview Rd. Clearwater, FL 33756
727-441-1571

Medical History

Although dental personnel primarily treat area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name _____ DOB _____

Are you under a physician's care now? □ YES □ NO If yes, please explain: _____
Have you ever been hospitalized/ had major surgery? □ YES □ NO If yes, please explain: _____
Have you ever had a serious head or neck injury? □ YES □ NO If yes, please explain: _____
Are you taking any medications, pills, or drugs? □ YES □ NO If yes, please explain: _____
Do you take or have you taken Phen-Fen or Redux? □ YES □ NO _____
Have you ever taken Fosamax, Boniva, Actenol or bisphosphonates? □ YES □ NO _____

Are you on a special diet? □ YES □ NO
Do you use tobacco? □ YES □ NO
Do you use controlled substances? □ YES □ NO

Women: Are you...
Pregnant / Trying to get pregnant? □ YES □ NO
Taking oral contraceptives? □ YES □ NO
Nursing? □ YES □ NO

Allergies: □ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal
□ Latex □ Sulfa Drugs □ Other: _____

AIDS/HIV Positive	□ YES □ NO	Cortisone Medicine	□ YES □ NO	Hemophilia	□ YES □ NO	Radiation Treatments	□ YES □ NO
Alzheimer's Disease	□ YES □ NO	Diabetes	□ YES □ NO	Hepatitis A	□ YES □ NO	Recent Weight Loss	□ YES □ NO
Anaphylaxis	□ YES □ NO	Drug Addiction	□ YES □ NO	Hepatitis B or C	□ YES □ NO	Renal Dialysis	□ YES □ NO
Anemia	□ YES □ NO	Easily Winded	□ YES □ NO	Herpes	□ YES □ NO	Rheumatic Fever	□ YES □ NO
Angina	□ YES □ NO	Emphysema	□ YES □ NO	High Blood Pressure	□ YES □ NO	Rheumatism	□ YES □ NO
Arthritis/Gout	□ YES □ NO	Epilepsy or Seizures	□ YES □ NO	High Cholesterol	□ YES □ NO	Scarlet Fever	□ YES □ NO
Artificial Heart Valve	□ YES □ NO	Excessive Bleeding	□ YES □ NO	Hives or Rash	□ YES □ NO	Shingles	□ YES □ NO
Artificial Joint	□ YES □ NO	Excessive Thirst	□ YES □ NO	Hypoglycemia	□ YES □ NO	Sickle Cell Disease	□ YES □ NO
Asthma	□ YES □ NO	Fainting Spills / Dizziness	□ YES □ NO	Irregular Heartbeat	□ YES □ NO	Sinus Trouble	□ YES □ NO
Blood Disease	□ YES □ NO	Frequent Cough	□ YES □ NO	Kidney Problems	□ YES □ NO	Spina Bifida	□ YES □ NO
Blood Transfusion	□ YES □ NO	Frequent Diarrhea	□ YES □ NO	Leukemia	□ YES □ NO	Stomach/Intestinal Disease	□ YES □ NO
Breathing Problem	□ YES □ NO	Frequent Headaches	□ YES □ NO	Liver Disease	□ YES □ NO	Stroke	□ YES □ NO
Bruise Easily	□ YES □ NO	Genital Herpes	□ YES □ NO	Low Blood Pressure	□ YES □ NO	Swelling of Limbs	□ YES □ NO
Cancer	□ YES □ NO	Glaucoma	□ YES □ NO	Lung Disease	□ YES □ NO	Thyroid Disease	□ YES □ NO
Chemotherapy	□ YES □ NO	Hay Fever	□ YES □ NO	Mitral Valve Prolapse	□ YES □ NO	Tonsillitis	□ YES □ NO
Chest Pains	□ YES □ NO	Heart Attack/Failure	□ YES □ NO	Osteoporosis	□ YES □ NO	Tuberculosis	□ YES □ NO
Cold Sores/Fever Blisters	□ YES □ NO	Heart Murmur	□ YES □ NO	Pain in Jaw Joints	□ YES □ NO	Tumors or Growths	□ YES □ NO
Congenital Heart Disorder	□ YES □ NO	Heart Pacemaker	□ YES □ NO	Parathyroid Disease	□ YES □ NO	Ulcers	□ YES □ NO
Convulsions	□ YES □ NO	Heart Trouble/Disease	□ YES □ NO	Psychiatric Care	□ YES □ NO	Venereal Disease	□ YES □ NO

Have you had an illness not listed above? □ YES □ NO _____

_____

_____
Patient or Guardian Signature Date

If there is not enough room to list all medications above, please list on the back of this form.

Soni Smiles
GENERAL & IMPLANT DENTISTRY

Soni Smiles General and Implant Dentistry
1511 Lakeview Rd. Clearwater, FL 33756
727-441-1571

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we 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" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff 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 the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. 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, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. 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 protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this **Notice of Privacy Practices.** Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications 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 may have the right to have your dentist amend your protected health information. 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. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient Name: _____ Signature: _____ Date: _____

Soni Smiles
GENERAL & IMPLANT DENTISTRY

Soni Smiles General and Implant Dentistry
1511 Lakeview Rd. Clearwater, FL 33756
727-441-1571

GUARANTEE OF PAYMENT

DENTAL INSURANCE IS NOT DESIGNED TO PAY FOR ALL DENTAL CARE. With there being over 400 different dental insurance companies and contracts, we realize how confusing dental insurance can be. As a courtesy we can help you identify a general breakdown of dental insurance benefits; however, the dental insurance contract is between yourself and the insurance company. Please take time to review your plan thoroughly. It is not our responsibility to identify specific clauses, limitations or exclusions of your dental insurance contract. **PLEASE UNDERSTAND YOU ARE FINANCIALLY RESPONSIBLE FOR WHAT THE INSURANCE COMPANY DOES NOT COVER.** Please feel free to ask any member of our front office personnel for clarification on services, billing and insurance.

APPOINTMENTS & CANCELLATIONS

We understand that there are times when you must miss an appointment due to emergencies or family and work obligations; however, when we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment to please give us at least 48 hours' notice. This courtesy makes it possible to give your reserved room to another patient who would very much need it.

There is a charge for not keeping your scheduled appointments. **IF AN APPOINTMENT IS NOT RESCHEDULED/CANCELLED AT LEAST 24 HOURS IN ADVANCE, YOU WILL BE CHARGED A $35 FAILED APPOINTMENT FEE.** This fee will not be covered by your insurance if you are insured. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

TARDY / LATE ARRIVAL

We strive to provide our patients with the best oral healthcare possible and understand that every patient's time, as well as ours, is valuable. A late arrival can take away designated time from fellow patients. Your prompt arrival is appreciated by other scheduled patients as well as the entire staff. Thank you in advance for arriving timely.

It is our policy that if a patient is more than 15 minutes late we may have to reschedule for another date and apply a failed appointment fee.

I, the undersigned patient, do agree by signing this statement, to pay for any services and/or dental treatment that are not paid by my insurance company. I also understand that in any event the insurance is expired, cancelled or inactive and my dental treatment is in progress, I will be responsible for the balance due upon completion of the services rendered, and any additional fees incurred to collect monies due.

Patient Name: _____

Patient signature: _____ Date: _____

Soni Smiles
GENERAL & IMPLANT DENTISTRY

Soni Smiles General and Implant Dentistry
1511 Lakeview Rd. Clearwater, FL 33756
727-441-1571

Authorization for Release of Information

Patient name:_____ Date of Birth __ __ / __ __ / __ __ __ __

I authorize the professional office of my dentist named above to release health information identifying me ([including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services).
Detailed description of the information to be released unless otherwise specified: Dental x-rays, Progress Notes and Dental Charts from **Soni Smiles General and Implant Dentistry**

To whom may the information be released [name(s) of recipients] if any:

Name(s): _____

_____

_____

Purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

_____

_____

_____

Expiration date or event relating to the individual or purpose for the release: __ __ / __ __ / __ __

Your decision to this authorization form is optional. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it at any time. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature:_____ Date: _____

OR Responsible Party Signature: _____ Date: _____

Soni Smiles
GENERAL & IMPLANT DENTISTRY

Soni Smiles General and Implant Dentistry
1511 Lakeview Rd. Clearwater, FL 33756
727-441-1571

Photography Release

I, _____, hereby authorize Ravi Soni and/or her staff to take photographs or videos including (but not limited to) my face, jaws, mouth and teeth.

I understand that the images will be used as a record of my care and may also be used for educational purposes or in marketing materials.

I further understand that if the images are used for educational purposes or in marketing materials, my name and any other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these images.

Signature _____ Date _____