Comfort Care Dental

Restorative and Sedation Dentistry

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help reach and maintain your maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you!

* *

Today's date ______________

Patient Information (confidential)

Your Name ______________________________ Birthdate ______________________

Residence Address ________________________ City ______________ State ____ Zip _____

Business Address _________________________ City ______________ State ____ Zip _____

Mailing Address (if different) ________________ City ______________ State ____ Zip _____

Home Telephone __________________________ Work Telephone ___________ cell: ________

Your Occupation __________________________ Place of Employment ________________

Your Social Security Number ________________ Email ______________________

Marital Status ____________________________ Spouse's Name ____________________

Spouse's Occupation _______________________ Spouse's Place of Employment __________

Spouse's Social Security Number _____________

Responsible Party

Person Responsible for this Account _______________ Relationship to Patient _________

Address (if different from above) _________________ City ______________ State ____ Zip _____

Employer _________________________________ Work Phone ______________________

Dental Insurance Information

Name of Insured ___________________________ Relationship to Patient ________________

Birthdate _______________ Social Security # ________________ Employer ______________

Insurance Company ______________ Group # ___________________ Policy # ___________

Date and Purpose of Last Dental Visit ______________ Purpose of Today's Visit ______________________

Do you have any dental concerns or expectations of your dental care that you would like to comment on?____

____

Whom may we thank for referring you? ____

Comfortable Complete Care

AMERICAN COLLEGE OF PROSTHODONTISTS®

John Seasholtz, II, D.M.D.
2003 Miccosukee Road | Tallahassee, FL 32308
Tel 850.877.3022 | Fax 850.877.4941
www.comfortcaredentist.com

John Seasholtz, II, D.M.D. 2005 Miccosukee Road Tallahassee, FL 32308
(850)877-3022

In order to provide the best possible care for you, we need your cooperation. Please read and answer the questions below. This information is kept in strict confidence to protect your privacy. Thank you!

PATIENT'S NAME _____ AGE: _____ SEX: _____

PARENT OF MINOR _____ DATE: _____

CLOSEST RELATIVE: _____ PHONE _____

History Reviewed

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

MEDICAL HISTORY

NO		YES	COMMENTS
☐	Care of physician? (who, why)	☐	
☐	Serious illness?	☐	
☐	Cancer, tumor, malignancy? (Type, when, where, treatment)	☐	
☐	AIDS	☐	
☐	Serious injuries?	☐	
☐	Hospital admissions?	☐	
☐	Operations? (what, when, where)	☐	
☐	Local Anesthetic (personal or family complications)	☐	
☐	General Anesthetic (personal or family complications)	☐	
☐	Transfusions? (why, when)	☐	
☐	Pregnancies? (past, present)	☐	
☐	Allergies? (food, drugs, other)	☐	
☐	Present medications (kinds, dosage)	☐	
☐	Illicit drugs (quality, quantity)	☐	
☐	Alcohol (quality, quantity)	☐	
☐	Tobacco (quality, quantity)	☐	

REVIEW OF SYSTEMS

IF YOU HAVE DIFFICULTY COMPLETING THIS SECTION, PLEASE ASK FOR ASSISTANCE FROM THE DOCTOR WHEN HE SEES YOU.

NO	CARDIOVASCULAR:	YES	COMMENTS
☐	Angina (chest pain)	☐	
☐	Heart attack	☐	
☐	Congenital heart defect	☐	
☐	Rheumatic fever	☐	
☐	Rheumatic heart disease	☐	
☐	Murmurs	☐	
☐	High blood pressure	☐	
☐	Stroke	☐	
☐	Other:	☐	

	RESPIRATORY		
☐	Tuberculosis	☐	
☐	Emphysema	☐	
☐	Asthma	☐	
☐	Shortness of breath	☐	
☐	" on exertion	☐	
☐	" at bedtime	☐	
☐	Edema (swollen lungs)	☐	
☐	Other:	☐	

	MUSCULOSKELETAL:		
☐	Arthritis	☐	
☐	Bone Disorders	☐	
☐	Fractures	☐	
☐	Muscular Disorders	☐	
☐	Other:	☐	

	GENITOURINARY:		
☐	Kidney Infections	☐	
☐	Venereal disease	☐	
☐	Other:	☐	

NO	ENDOCRINE:	YES	COMMENTS
☐	Diabetes	☐	
☐	Adrenal disorders	☐	
☐	Thyroid disorders	☐	
☐	Parathyroid disorders	☐	
☐	Steroids	☐	
☐	Other:	☐	

	HEMATOPOIETIC		
☐	Anemia	☐	
☐	Bleeding disorders	☐	
☐	Blood thinners	☐	
☐	Leukemia	☐	
☐	Other:	☐	

	NEUROLOGIC:		
☐	Paralysis	☐	
☐	Epilepsy	☐	
☐	Convulsions	☐	
☐	Psychiatric treatment	☐	
☐	Faints/Spells	☐	
☐	Tranquilizers	☐	
☐	Other:	☐	

	GASTROINTESTINAL/LIVER:		
☐	Ulcers	☐	
☐	Bleeding	☐	
☐	Hepatitis	☐	
☐	Jaundice	☐	
☐	Cirrhosis of liver	☐	
☐	Other:	☐	

Sedation/Medical Sheet

Do you have Glaucoma?	Yes ☐	No ☐
Do you have an allergy to latex?	Yes ☐	No ☐
Have you ever had a joint replaced?	Yes ☐	No ☐
Have you ever been exposed to HIV?	Yes ☐	No ☐
Do you consume grapefruits or the juice?	Yes ☐	No ☐
Do you take the herb St. John's Wort?	Yes ☐	No ☐
Are you currently taking Tagamet (Cimetidine)?	Yes ☐	No ☐

If yes, how often? _____

Do you take antacids?	Yes ☐	No ☐

If yes, how often? _____

STOP HERE! The doctor will fill out the questions below.

Inducers
Barbiturates
Carbamarepine (Tegretol)
Phenytoin (Dilantin)
Rifampin
St. John's Wort
Omeprazole (Prilosec)

Contra
Acute Narrow-Angle Glaucoma
Pregnancy
Alcohol or Substance Abuse
Breastfeeding
Advanced Psychosis

Inhibitors
Clarithromycin (Biaxin)
Azithromycin (Zithromax)
Erythromycin
Cyllosporine
Fluconazole (Diflucan)
Ketaconazole
Any Systemic Antifungals
Grapefruit Juice
Cimetidine (Tagamet)
Nefazodone (Serzone)
CCBS (esp. Diltiazem)
Antacids
Protease Inhibitors (AZT)
Benadryl (Don't Use With Zalepion (Sonata)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $23.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Libby Freer

Telephone: (850)877-3022 Fax: (850)877-4941

E-mail: NA

Address: 2003 Miccosukee Road, Tallahassee, FL 32308

A message from the practice of John Seasholtz, II, D.M.D.

Dear Patient:

Recently the U.S. government established new rules concerning the use and protection of medical and health information. This initiative wa part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The rules are intended to provide standard privacy protections for your medical information. We regard the privacy of our patients as a central part of our mission to serve the needs of the patient first. The Notice of Privacy Practices provided you with information explaining how we use your medical information.

Please sign below to acknowledge that you have received the notice concerning our policy regarding privacy practices.

Notice of Privace Practices Acknowledgement Form

Patient Name _____

I acknowledge that the office of John Seasholtz, II, D.M.D. has provided me with a copy of their Notice of Privacy Practices. I understand this acknowledgment means only that I have received the notice, and in no way affects the care I receive.

Please sign this form and return it to our office manager.

Signature _____ **Date**_____

Relationship to patient (if not patient) _____