

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Patient # _____
Address _____ City _____ SS#/SIN _____
Email _____ Date _____
Home Phone _____
State/Prov. _____ Zip/P.C. _____
Cell Phone _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer: Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you wearing contact lenses?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you allergic to or have you had any reactions to the following? | | |
| 3. Are you taking any medication(s) including non-prescription medicine?.....
If yes, what medication(s) are you taking? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?..... | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you use controlled substances?..... | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have or have you had any of the following? | | | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any Metals (e.g. nickel, mercury, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other (please list) _____ | | |
| | | | 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 13. Women Only: | | |
| | | | a) Are you pregnant or think you may be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c) Are you taking oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No | | Yes | No | | Yes | No |
|-----------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| High Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack..... | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur..... | <input type="checkbox"/> | <input type="checkbox"/> | Stroke..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles..... | <input type="checkbox"/> | <input type="checkbox"/> | Angina..... | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired..... | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> | Anemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions..... | <input type="checkbox"/> | <input type="checkbox"/> | Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases..... | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Jaundice..... | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection..... | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|-------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?..... | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Do you wear dentures or partials?.....
If yes, date of placement _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking..... | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Difficulty in chewing..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____
Signature of patient (or parent/guardian if minor)

Doctor's Comments _____
<div style="display: flex; justify-content: space-between;"> Signature Date </div>

Blanding Dental Associates

Dr. John Chamberlain and Dr. Gerald Cioffi

767 Blanding Blvd Suite 108, Orange Park, FL 32065

904-272-6244

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 10/01/2019, 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.____ for each page, \$____ 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: Cheri

Telephone: 904-272-6244 Fax: 904-276-0038

E-mail: _____

Address: 7107 Bleeding Heart Blvd, Suite 108
Orlando Park, FL 32065



Blanding Dental Associates

Dr. John Chamberlain and Dr. Gerald Cioffi

767 Blanding Blvd Suite 108, Orange Park, FL 32065

904-272-6244

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for BLANDING DENTAL ASSOCIATES this ___ day of _____, 20 __.

A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please print your name

Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority _____.

Thank you and if you have any questions about this form or the attached Notice, please contact our Privacy Office, Cheri.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because _____

Other (please describe) _____



Blanding Dental Associates

Dr. John Chamberlain and Dr. Gerald Cioffi

767 Blanding Blvd Suite 108, Orange Park, FL 32065

FINANCIAL POLICY

Payments: It is the responsibility of the patient or guarantor seeking treatment to pay any deductible, co-insurance, or co-pay amounts at the time services are rendered. We accept cash, personal checks, Master Card and Visa. Returned checks are subject to a \$75.00 fee and you may lose your privilege to write checks for any future visit.

Filing Insurance: If your insurance is not one we have an agreement with, a claim will be filed for you as a courtesy, if requested. It is your responsibility to verify with your insurance company that we are on your participating provider list. We will allow 45 days for your insurance company to settle your account. If payment has not been received within the 45 days, please be advised the balance on your account will then become your responsibility to pay in full.

Children, as patients, of divorced parents: Payment is due at the time of service no matter who is responsible by order of the Divorce Decree.

Financial Agreement: We will gladly discuss the cost of your proposed treatment and do our best to answer any questions relating to your insurance.

You must realize, however that:

Your insurance is a contract between you your employer, and the insurance company. We are not a party to that contract.

1. We make every effort to meet the requirements of the different insurance companies, but you are ultimately responsible to know what your policy covers and requires.

2. We are a MERCURY-FREE/AMALGAM-FREE PRACTICE. We use the highest quality and most state-of-the-art restorative materials. Some insurance companies will only provide a benefit of an amalgam filling towards posterior (back tooth) restorations. You will be responsible for the difference.

3. **BROKEN APPOINTMENTS:** There will be a \$85.00 for each broken appointment without 24 hour advanced notice.

We must emphasize that as a health care provider, our relationship is with you and not your insurance company.

We realize that emergencies may affect timely payment on your account. If such extreme cases do occur, please contact us properly for assistance. In the event your account goes to a collection agency, and additional 40% collection fee will be added to your account and you will no longer be eligible to obtain dental/medical services from us.

I have read and understand the above Financial Policy.

Signature of Patient or Responsible Party

Date