Coral Springs SMILE CARE

## Patient Information:

(This information is necessary for our files and will be considered CONFIDENTIAL)

Patient's Name:_____ Preferred Name:_____
Last First Initial

**Patient Is**: ☐ Responsible Party **OR** ☐ Dependent Email Address:_____

Home Address:_____
Street City State Zip Code

**Date of Birth:**___/____/_____ **Social Security No**. _____ **Driver's License No**._____

Cell Phone: (____)- _____-_____ Work Phone: (____)- _____-_____ Alternate Phone No.: (____)- _____-_____

**Sex**: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

**Whom may we contact in the case of an emergency?** _____ Phone No. (____)- _____-_____

**Name of nearest relative not living with you:** _____ Phone No. (____)- _____-_____

Name of Physician (Primary Care):_____ Phone No. (____)- _____-_____

Previous Dentist: _____ Phone No. (____)- _____-_____

**Whom may we thank for referring you?**_____

## Financial Information:

Person responsible for this account:_____ Phone No. (____)- _____-_____

Address:_____ Relationship:_____
Street City State Zip Code

Preference of Payment: ☐ Cash on day of treatment ☐ Credit Card

## Insurance Information:

Name of Insurance Company **(Primary Insurance)** _____ Phone No. (____)- _____-_____

Insured's Name: _____ Relationship:_____

Member ID:_____ Date of Birth:_____/_____/_____ Social Security No. _____

Name of Group Dental Plan:_____ Group No.:_____

Name of Insurance Company **(Secondary Insurance)** _____ Phone No. (____)- _____-_____

Insured's Name:_____ Relationship:_____

Member ID: _____ Date of Birth:_____/_____/_____ Social Security No. _____

Name of Group Dental Plan:_____ Group No.:_____

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**Patient Medical History:**

**Patient Full Name**:_____ **Date of Birth**:_____/_____/_____

Although dental personnel treat in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or had in the past, including medications that you currently or have been taking may have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physicians care now? Yes ☐ No ☐ If yes, please explain_____
Have you been hospitalized or had a major operation? 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._____
Have you ever taken Fosamax,Boniva, Actonel or any other medications containing bisphosphonates? Yes ☐ No ☐ _____
Do you take or have you ever taken Phen-Fen or Rudex? Yes ☐ No ☐ If yes, please explain:_____
Are you on a special diet? Yes ☐ No ☐ If yes, please explain._____
Do you use tobacco? Yes ☐ No ☐ If yes, please explain:_____
Do you use controlled substances? Yes ☐ No ☐ If yes, please explain:_____

**Please Circle your answer:**

**Women: Are you?** Y / N

Taking Contraceptives? Yes☐No☐ Pregnant/Trying to conceive? Yes☐No☐(If yes, due date?_____) Nursing? ☐ ☐

**Are allergic to any of the following?**

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

| | Y / N | | Y / N | | Y / N | | Y / N |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ☐ ☐ | Cortisone Medicine | ☐ ☐ | Hemophilia | ☐ ☐ | Renal Dialysis | ☐ ☐ |
| Alzheimer's Disease | ☐ ☐ | Diabetes | ☐ ☐ | Hepatitis A | ☐ ☐ | Rheumatic Fever | ☐ ☐ |
| Anaphylaxis | ☐ ☐ | Drug Addiction | ☐ ☐ | Hepatitis B or C | ☐ ☐ | Rheumatism | ☐ ☐ |
| Anemia Angina | ☐ ☐ | Easily Winded | ☐ ☐ | Herpes | ☐ ☐ | Scarlet Fever | ☐ ☐ |
| Arthritis/Gout | ☐ ☐ | Emphysema | ☐ ☐ | High Blood Pressure | ☐ ☐ | Shingles | ☐ ☐ |
| Artificial Heart Valve | ☐ ☐ | Epilepsy or Seizures | ☐ ☐ | Hives or Rash | ☐ ☐ | Sickle Cell Disease | ☐ ☐ |
| Artificial Joint | ☐ ☐ | Excessive Bleeding | ☐ ☐ | Hypoglycemia | ☐ ☐ | Sinus Trouble | ☐ ☐ |
| Asthma | ☐ ☐ | Excessive Thirst | ☐ ☐ | Irregular Heartbeat | ☐ ☐ | Spina Bifida | ☐ ☐ |
| Blood Disease | ☐ ☐ | Fainting or Dizziness | ☐ ☐ | Kidney Problems | ☐ ☐ | Intestinal Disease | ☐ ☐ |
| Blood Transfusion | ☐ ☐ | Frequent Cough | ☐ ☐ | Leukemia | ☐ ☐ | Stroke | ☐ ☐ |
| Breathing Problem | ☐ ☐ | Frequent Diarrhea | ☐ ☐ | Liver Disease | ☐ ☐ | Swelling of Limbs | ☐ ☐ |
| Bruise Easily | ☐ ☐ | Frequent Headaches | ☐ ☐ | Low Blood Pressure | ☐ ☐ | Thyroid Disease | ☐ ☐ |
| Cancer | ☐ ☐ | Genital Herpes | ☐ ☐ | Lung Disease | ☐ ☐ | Tonsillitis | ☐ ☐ |
| Chemotherapy | ☐ ☐ | Glaucoma | ☐ ☐ | Mitral Valve Prolapse | ☐ ☐ | Tuberculosis | ☐ ☐ |
| Chest Pains | ☐ ☐ | Hay Fever | ☐ ☐ | Pain in Jaw Joints | ☐ ☐ | Tumors or Growths | ☐ ☐ |
| ColdSores/Fever/Blister | ☐ ☐ | Heart Attack/Failure | ☐ ☐ | Parathyroid Disease | ☐ ☐ | Ulcers | ☐ ☐ |
| CongenitalHeartDisorder | ☐ ☐ | Heart Murmur | ☐ ☐ | Psychiatric Care | ☐ ☐ | Venereal Disease | ☐ ☐ |
| Convulsions | ☐ ☐ | Heart Pace Maker | ☐ ☐ | Radiation Treatment | ☐ ☐ | Yellow Jaundice | ☐ ☐ |
| | | Heart Trouble/Disease | ☐ ☐ | Recent Weight Loss | ☐ ☐ | | |

Comments: _____

Patient's Signature_____ Dentist's Signature_____ Date_____

Coral Springs SMILE CARE

# Welcome!

We, the staff of MANKAME, DIPAK M., D.D.S., P.A. thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact Kimberley Worthingtom or Eileen Vargas at 954-791-1630.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.
We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, American Express, Discover and Care Credit). Unfortunately, we do not accept personal checks.
Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

**Interest**

Interest will incur if a balance remains unpaid after 60 days.

**Insurance**

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, co-insurance and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the National Provider Compliance Corporation 91 filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with, your carrier we will not negotiate reduced fees with your carrier.

**Miscellaneous Forms, Additional Information and Authorizations**

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports or extracurricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

**Missed Appointments and After Hours Visits**

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $50.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients. A fee of $70.00 applies to any emergency, after-hour dental care.

**Medical Records Fees**

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records

and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

**Timeliness of Appointments**

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Patient or Authorized Representative: _____Date: _____

**CONSENT FOR TREATMENT**

I certify that I read, speak and understand the English language and grant permission to MANKAME, DIPAK M., D.D.S and/or his associates and his staff to administer to myself, my child or legal ward, such medications and procedures that they deem necessary, in their professional judgment, for my oral and dental health. Also, I grant my permission for them to administer local anesthetics and other medically indicated drugs or pharmaceuticals that they deem necessary, to use such operative and technical procedures necessary to complete a diagnosis and/or recommended and accepted treatment. I also grant permission to acquire and use all or any part of my records, photographs, videotapes or films which may be required for examination, diagnosis and treatment.

Signature of Patient or Authorized Representative_____Date:_____

Coral Springs SMILE CARE

## ACKNOWLEDGMENT OF

## RECEIPT OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

The undersigned acknowledges receipt of copy of the currently effective Notice of Privacy Practices for Plantation Smile Care, Mankame Dipak M., D.D.S.,P.A.,F.A.G.D.

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/ parent / guardian 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 Official.

**Office Use Only**

As Privacy Official, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment 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 | ____ |
| Reason (please describe) | |

_____

Signature of privacy official

Coral Springs SMILE CARE

# NOTICE OF PRIVACY PRACTICES

This notice describes how medical & dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully

**1. Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy, usually within 30 days of your request. We may charge a reasonable cost-based fee for copying and postage as authorized by the Florida Board of Dentistry but we will not condition copying upon payment of a fee for services rendered.
Ask us to correct your medical record that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. Your request must specify alternative means and location and provide satisfactory explanation of how payments will be handled with your request.

Ask us to limit what we use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated by contacting us using the information listed at the bottom of this Notice. You can file a complaint with the U.S. Department of Health and Human Services. Upon request, we will provide you with the address to file a complaint with the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

**2. Your Choices**

For certain health information, you can tell us your choices about what we share and your clear preference for how we share your information and we will follow your instructions. In these cases, you have both the right and choice to tell us to: share information with your family, close friends, or others involved in your care, share information in a disaster relief situation. If you are not able to tell us your preference, (for example, if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission and the written permission specifically lists the type of information being disclosed and prevents re-disclosure: Marketing purposes, Sale of your information, most sharing of notes regarding psychotherapy, HIV and/or substance abuse. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

**3. Our Uses and Disclosures**

We typically use or share your health information in the following ways:
Treat you- We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization- We can use and share your health information to run our practice, improve your care and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
Bill for your services- We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*
We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
Help with public health and safety issues- for certain situations, such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Comply with the law- We will share information about you if state or federal laws require it.
Work with a medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests- We can use or share health information about you: for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities- We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our web site.

Other Information-. We do not create or manage a hospital directory. We do not create or maintain psychotherapy and/or substance abuse information at this practice. We do not receive financial remuneration for marketing products or services in this practice. We do not sell patient information in this practice. We do not engage in fundraising at this practice. We may ask about HIV status because it is pertinent to your dental care but will make no further disclosure of such information without specific written consent from you or as otherwise required by law. We will never share any psychotherapy, HIV or substance abuse records without your written permission. A. We will ask you to sign a separate written consent form that specifically mentions this type of information before we release this type of information. If you direct us to release this type of information, we will instruct the recipient that further disclosure by the recipient requires your specific written consent. Under Florida law, we are unable to submit claims to payers (your health plan) under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing a Consent form but, unless you pay in full out-of-pocket, we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or revoke it.
Marketing Health-Related Services & Appointment Reminders: We may occasionally use your health information to send you marketing communications for special or discounted products or services unless directed by you not to do so. To do so we may use voicemail messages, email messages, text messages (SMS), postcards, or letters. We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, email messages; text messages (SMS), postcards, or letters. We may send these messages directly from our office systems and/or utilize a vendor who has signed a Business Associate Agreement with us and agrees to comply with all required HIPAA/HITECH rules to ensure the security and privacy of your information.

Cookies- Our website utilizes "cookie" technology. "Cookies" are encrypted strings of text that a website stores on a user's computer. Our website uses cookies throughout the online process to keep together information entered on multiple pages. For example, cookies enable our website to "remember" information provided to us. In addition, cookies are used to: Measure usage of various pages on our website to help us make our information more pertinent to your needs and easy for you to access; and, Provide functionality such as online appointing, bill paying and other functionality that we believe would be of interest and value to you.

The two types of cookies that we use are referred to as "session" cookies and "persistent" cookies. Session cookies are temporary and are automatically deleted once you leave our website. Persistent cookies remain on your computer hard drive until you delete them. We do not use cookies to gather any personally identifiable information about you apart from what you voluntarily provide us in your dealings with us. Our cookies do not corrupt or damage your computer, programs or computer files. You may set your browser to block cookies.

**Notice Effective 9/23/2013.**

Coral Springs SMILE CARE

## Getting to Know You (Optional)

Dr. Mankame and his associates strive to give you exceptional dental care. This questioner will allow us to get to know some things about you and better treat you according to your own personal needs. Thank you for taking the time to help us get to know you!

If you could wave a magic wand and change one thing about your smile, what would it be?_____

If there was a simple, inexpensive way to whiten your smile would you be interested? Yes ☐ No ☐

What did you like best about your last dentist?

Why did you leave your last dentist?

When was your last dental visit?

Have you ever had a serious problem associated with previous dental treatment? Yes ☐ No ☐

If yes, please explain: _____

How often do you brush your teeth? _____

Floss?

Do you routinely use mouth wash? Yes ☐ No ☐

Do you experience dry mouth (Xerostomia)? Yes ☐ No ☐

Do your gums feel tender or swollen? Yes ☐ No ☐

Do you avoid brushing any part of your mouth because of tenderness? Yes ☐ No ☐

If yes, please explain: _____

Do you feel twinges of pain or sensitivity when your teeth come in contact with: ☐ Hot ☐ Cold ☐ Sweet ☐ Sour

What texture of tooth brush do you prefer? ☐ Soft ☐ Medium ☐ Hard

Does food catch between your teeth? Yes ☐ No ☐

Do you feel your teeth are affecting your health in any way? Yes ☐ No ☐

Do you clench or grid your teeth while sleeping or during the day? Yes ☐ No ☐

Do your facial muscles ever feel tired? Yes ☐ No ☐

Do you wear partial dentures or full dentures? Yes ☐ No ☐

If so, do you feel you have retention problems with your full or partial dentures? Yes ☐ No ☐

Do you gag easily? Yes ☐ No ☐

Are you apprehensive (nervous) about your dental treatment? Yes ☐ No ☐

If yes, what makes you nervous about visiting the dentist?

_____

_____