

WELCOME

Thank you for choosing our dental healthcare team! We will strive to provide you with the best possible dental care.

PERSONAL INFORMATION

Date _____ Date of Birth _____

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Driver's License # _____

Male/ Female Marital Status: Married Single Minor/child

Employer _____ Occupation _____

Referred by: _____

INSURANCE INFORMATION

Primary Insurance

Name of Insured _____ Date of Birth of Insured _____

Relationship to patient _____ Soc. Sec. # _____

Insurance Company _____ ID # _____

Group # _____ Employer _____

Secondary Insurance

Name of Insured _____ Date of Birth of Insured _____

Relationship to patient _____ Soc. Sec. # _____

Insurance Company _____ ID # _____

Group # _____ Employer _____

OFFICE POLICY

WELCOME TO THE OFFICE OF RICK K. HARRISON D.M.D., PA

In most cases payment is due at the time of service. Dental Plans are not insurance. They are a reduced fee schedule and payment is due in full at the time service.

There will be a \$25.00 charge for an appointment that is broken or canceled without twenty-four (24) hours notice. There are no refunds or returns on any products purchased through this office. The reason for this policy is oral hygiene and prescription products cannot be resold once they leave the office.

I give permission for my dentist and dental team to use my photographs for in-office patient education.

When supplied with the proper information regarding insurance, and upon verification of insurance coverage, our office will be pleased to file your insurance claim as a courtesy to you. You will be given a pre-estimate of your portion including any deductibles, which are payable when the treatment is rendered. I authorize and request my insurance company to pay directly to Rick K. Harrison, DMD, PA insurance benefits for any services rendered to me or my dependents.

We will file secondary insurance as a courtesy only; estimated co-pay will be based on primary insurance only.

It must be fully understood, however that insurance is an agreement (contract) between you and your insurance company and that you are solely responsible for any amount not paid by insurance company.

Upon final payment or denial from your insurance company, you will receive a statement from this office informing you of their decision to either deny payment or of the amount being paid.

Any payment arrangements must be made in advance of treatment being rendered and must be kept current.

Outstanding balances: Each month statements are mailed to show any payments or credits applied to an account. In the event collection procedures are necessary, any attorney fees/collection fees will be added to your account and payable by you.

Original x-ray film and records are maintained in this office for a minimum of four (4) years after the last date being examined or treated by this office, which is in compliance with Florida Law 64B5-17.002 (2, 3).

If you bring x-rays with you from another office and Dr Harrison uses them for diagnosis, these x-rays cannot be duplicated if they are duplicates and these remain with the chart as described above. Due to the high cost of x-ray duplication film, it is necessary to charge for x-ray duplication, if needed for any reason. Fee for duplication is \$35.00. This is in compliance with Florida State Law 455.018 and 64B5-17.009.

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

1. We require the insured person to fill out and sign the Dental Insurance Information and Authorization and Release portion of the Welcome Sheet to keep in the chart, provide our office with a complete dental benefit book, for your coverage.
2. We file electronically daily, your insurance company should respond within thirty (30) days. If your insurance company has not paid within forty-five (45) days after filing, you are responsible for the balance on the account. When or if the insurance company pays after forty-five (45) days, you will receive a refund of any credit on the account. In the case of any treatment which involves lab fees, the balance must be paid in full before delivery of the appliance, if the insurance pre-estimate has not been received by this office.
3. If you discontinue in the middle of treatment (EXAMPLE: Crowns are two (2) appointment procedures) the balance is due and payable at the time the treatment is terminated.
4. Although we will make every attempt to verify your insurance coverage and benefits at the time of your appointment, if for any reason your insurance claim is denied, you are solely responsible for the entire balance on the account.
5. Any disputes with the insurance company are your responsibility.
6. Coordination of benefits between indemnity insurance and a dental plan may or may not be possible, but will be handled on a case by case situation. The dentist is eligible for any fees not listed on the dental plan, but are covered and paid by the indemnity insurance. The patient is responsible for up to the dental plan fees listed on their dental plan fee schedule and/or lab fees or other non-covered procedures at the time of service.

REMEMBER: WE FILE YOUR INSURANCE AS A COURTESY TO YOU.

If you have read, understand and agree with all of the above policies date and sign this form.

Date

Patient or Responsible Party

Release to Use Photographs, Video, Name and Other Reproductions

I hereby grant to Rick K. Harrison DMD, PA and its employees, legal representatives and assigns in the performance of their duties for Rick K. Harrison DMD, PA, the absolute right and permission to use or copyright, in its own name or otherwise, and re-use, publish, and re-publish photographic pictures, video, electronic images or other reproductions of me or in which I may be included, in whole or in part, without restriction as to changes or alterations, in conjunction with or without my own name in color or otherwise, made through any medium, and in any and all media now or hereafter known for illustration, promotion, art, advertising, trade, including film, photographic, video, electronic or digital formats or reproductions, or any other purpose whatsoever. I also consent to use of any printed or electronic matter in conjunction therewith. The uses and rights granted herein are donated to Rick K. Harrison DMD, PA freely and without financial consideration as a public service.

I hereby waive any right that I may have to inspect or approve the finished product or products and the advertising copy or other matter that may be used in connection therewith or the use to which it may be applied.

I hereby release, discharge and agree to hold harmless Rick K. Harrison DMD, PA, its employees, department, legal representatives and assigns, and all persons acting under this Release, from any liability for such use, including by virtue of any blurring, distortion, alteration, optical illusion, of use in composite form, whether intentional or otherwise, that may occur or be produced in such use or in any subsequent processing thereof, as well as any publication thereof, including without limitation any claims for libel or invasion or privacy.

I hereby warrant that I am of legal age and have the right to contract in my own name or I am the parent or legal guardian of the subject for whom this Release is granted. I have read the above Release, prior to its execution, and I am fully familiar with and understand the contents thereof. This Release shall be binding upon me and my heirs, legal representatives, and assigns.

Signature: _____ Date: _____

Print Name: _____

Name of other person for whom release is given (if applicable):

Relationship of such person to signer: _____

Health History

Name: _____ Birthdate _____ Date _____

Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? _ Soft _ Medium _ Hard

5. Do your gums bleed while brushing? Yes No
6. Do your gums bleed when flossing? Yes No
7. Do you feel pain to any of your teeth when brushing or flossing them? Yes No
8. Have you noticed any loosening of your teeth? Yes No
9. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? Yes No
10. Does food tend to become caught between your teeth? Yes No
11. Do you have any sores or lumps in or near your mouth? Yes No
12. Have you ever experienced any of the following problems in your jaw?
 - a. Clicking Yes No
 - b. Pain Yes No
 - c. Difficulty in opening or closing Yes No
 - d. Difficulty in chewing Yes No
13. Have you ever had an upsetting experience in a dental office? Yes No
14. Have you had any head, neck, or jaw injuries Yes No
15. Do you have frequent headaches? Yes No
16. Do you clench or grind your teeth? Yes No
17. Do you bite your lips or cheeks frequently? Yes No
18. Have you ever had:
 - a. Orthodontic(braces) Yes No
 - b. Oral Surgery Yes No
 - c. Gum Treatment Yes No
 - d. Teeth ground or bite adjusted? Yes No
 - e. Wore a bite plane or other appliance? Yes No
19. Are you satisfied with the appearance of your teeth? Yes No
20. Anything that bothers you about dental treatment? Yes No

Medical History

1. Are you in good health? Yes No
2. Have there been any changes in your general health? Yes No
3. Date of your last physical exam: _____
4. Physicians name: _____
Address: _____
Phone No. _____
5. Are you under the care of a physician? Yes No
6. Have you ever been hospitalized? Yes No
7. Had any abnormal bleeding? Yes No
8. Do you bruise easily? Yes No
9. Ever required a blood transfusion? Yes No
10. Had a recent weight loss? Yes No
11. Do you use tobacco? Yes No
12. Do you use alcohol, cocaine, or other drugs? Yes No
13. Wear Contact lenses? Yes No

Medical History Continued...

Are you taking any medicines? Yes No

If yes, please list: _____

- | | | |
|--------------------------------------------------------|--------|----------------------------------------------------------|
| Are you allergic to or had a reaction to: | | |
| 1. Local anesthetics like novocaine? | Yes No | 15. Glaucoma? Yes No |
| 2. Penicillin or other antibiotics? | Yes No | 16. Heart Surgery? Yes No |
| 3. Sulfa drugs? | Yes No | 17. High Blood Pressure? Yes No |
| 4. Aspirin? | Yes No | 18. Low Blood Pressure? Yes No |
| 5. Iodine? | Yes No | 19. Hepatitis, jaundice or
liver disease? Yes No |
| 6. Other? _____ | | 20. Stroke? Yes No |
| Do you have or have ever had the following: | | 21. Sinus trouble? Yes No |
| 7. Rheumatic heart disease or fever? | Yes No | 22. Lung/Breathing problems? Yes No |
| 8. Scarlet fever? | Yes No | 23. Asthma or hay fever? Yes No |
| 9. Heart defect or murmur? | Yes No | 24. Hives or skin rash? Yes No |
| 10. Heart trouble, heart attack, angina? | Yes No | 25. Fainting spells or seizures? Yes No |
| a. Have pain in your chest upon
exertion? | Yes No | 26. Diabetes? Yes No |
| b. Ever short of breath after mild
exercise? | Yes No | 27. AIDS or HIV? Yes No |
| c. Do your ankles swell? | Yes No | 28. Thyroid problems? Yes No |
| d. Short of breath when laying? | Yes No | 29. Allergies? Yes No |
| e. Require extra pillows when
sleeping? | Yes No | 30. Arthritis or rheumatism? Yes No |
| 11. Tuberculosis? | Yes No | 31. Joint replacement or
implant? Yes No |
| 12. Persistent cough? | Yes No | 32. Stomach ulcer? Yes No |
| 13. Cough that produces blood? | Yes No | 33. STD? Yes No |
| 14. Cancer? | Yes No | 34. Epilepsy? Yes No |
| | | 35. Anemia? Yes No |
| | | 36. Leukemia? Yes No |
| Any other medical condition not mentioned above? _____ | | |

Women Only:

- | | |
|----------------------------------|--------|
| 1. Are you pregnant? | Yes No |
| 2. Are you nursing? | Yes No |
| 3. Are you taking birth control? | Yes No |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature

Date

Rick K. Harrison, DMD, PA

**Disclosure—Bisphosphonate Therapy
And Consent To Conservative Non-Surgical Therapy**

Bisphosphonates are a type of drug given to millions of Americans to treat osteoporosis or as part of cancer treatment, namely for breast cancer, lung cancer, prostate cancer, multiple myeloma, Paget’s disease of the bone, alveolar necrosis of the bone or post-menopausal osteoporosis. They are sometimes given orally and other times are given through people’s veins. Some of the common names include but are not limited to:

- | | | |
|-----------------------------|-----------------------|-----------------------|
| Actonel (Risedronate) | Bonefos (Clodronate) | Fosamax (Alendronate) |
| Fosamax Plus D(Alendronate) | Aredia (Pamidronate) | Ostac |
| Boniva (Ibandronate) | Didronel (Etidronate) | Skelid (Tiludronate) |
| Zometa (Zolendronic Acid) | Pamidronate | |

In rare instances, some people on these drugs have developed a condition called **osteonecrosis** of the jaw, which results in severe damage to or loss of the jaw bone. Symptoms include but are not limited to pain, swelling or infection of the gums or jaw, gums that are not healing, loose teeth, numbness or a heavy feeling in the jaw, drainage and exposed bone. There is no proven treatment to fix the problem.

Accordingly, patients on these drugs should know the risks, benefits and alternatives of the invasive dental procedures. If a patient is on bisphosphonates, Rick K. Harrison, DMD, PA, follows special procedures to promote the safety of the patient. It is very important that you let Dr. Harrison know whether you are taking any medications, particularly a bisphosphonate drug, or if you have ever taken a bisphosphonate drug. If you are unsure if the drugs you are taking are bisphosphonates, ask Dr. Harrison. You have a duty and responsibility to tell Dr. Harrison all the drugs that you take.

I hereby disclose that:

YES, I AM on a bisphosphonates or have taken one in the past. It is called:

_____.

I have taken this medication for: _____(amount of time)

NO, I am NOT on any bisphosphonates and have never taken or been given bisphosphonates.

_____	_____	_____
Print Name	Signature	Date

If you checked “YES” above, complete the following:

I understand that the complications stated above can happen with non-surgical (cleaning and root plannings) treatment as well as spontaneously and agree to proceed with the non-surgical treatment.

_____	_____	_____
Print Name	Signature	Date

Smile Evaluation Form

Name: _____ Date of Birth: _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Welcome to our Healthy Mouth Practice!

Please take a few minutes to answer the following questions. Thank you.

Please check any of the following problems that apply to you:

Sensitivity (hot or cold) Headaches Teeth or fillings break Grinding/Clenching Teeth
Bleeding, swollen, or irritated gums loose, tipped, shifting, or crowded teeth Bad Breath

Do you have or have you had any of the following?:

Dentures Partial Dentures Veneers or Crowns Braces or Invisalign If so when? _____

Periodontal (gum) treatments If so when? _____

Please Share the approximate dates of:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete set of x-rays _____

What are the most important things to you about your smile and your dental health?

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How long would you like to keep your teeth?

5-10 years 15-20 years your lifetime

How many times a week do you use floss? _____

How many times a day do you brush? _____ type of brush Hard medium soft

Do you smoke or use chewing tobacco? Yes No How much and for how long? _____

If you could change your smile, would you: (check all that apply)

Make your teeth straighter make your teeth whiter replace colored fillings replace missing teeth

Close spaces between teeth repair broken, chipped, or worn teeth complete smile makeover

Please rate the following on a scale of 1-5 with 5 being the highest:

How important is your dental health to you? _____

How would you rate your current dental health? _____

Where do you want your dental health care to be? _____

Are there any special events in your near future? _____

If there was anything you could change about your smile what would it be?

What is the most important goal of your visit today? _____

Please indicate any other concerns not specified

RICK K. HARRISON, D.M.D., P.A.

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 07/01/04, 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 data. 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 persons 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 prescription, 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, \$35 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.

Rick K. Harrison, D.M.D., P.A.
Attention: Jessica N. Harrison
227 11TH Avenue South, Jacksonville Beach, Florida 32250
Contact Person: Jessica N. Harrison

RICK K. HARRISON, D.M.D., P.A.

CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security _____

SECTION B: TO THE PATIENT --- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting

Contact Person: _____ Jessica N. Harrison _____

Telephone: _____ (904) 241-4237 _____ Fax: _____ (904) 249-7980 _____

Address: _____ Rick K. Harrison, D.M.D., P.A.
Attention: Jessica N. Harrison
227 11TH Avenue South, Jacksonville Beach, Florida 32250

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contract Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name: _____

Relationship to Patient: _____

RICK K. HARRISON, D.M.D., PA

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- “ Individual refused to sign
- “ Communications barriers prohibited obtaining the acknowledgement
- “ An emergency situation prevented us from obtaining acknowledgement
- “ Other (Please Specify)

