Patient Information

Patient Name: ______________________________ Date:
Last, First MI (Preferred Name)
Gender: __________ Family Status: __________
Birth Date: ______________________________
Phone (Home): (__________ (Work): __________ Ext: ______ Best time to call: __________
Address: ______________________________
Street Apartment #
City State/Province Zip/Postal Code

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: ______________

Is your child under medical care now? ☐ Yes ☐No

If yes:
____

Has your child ever been hospitalized or had an operation? ☐ Yes ☐No

If yes:
____

Is your child taking any medications, pills, or drugs? ☐ Yes ☐No

If yes:
____

Does your child have any allergies? i.e. penicillin, latex, sulfa drugs? ☐ Yes ☐No

If yes:
____

Do you have a specific dental concern you would like us to address? ☐ Yes ☐No

If yes:
____

Does your child have any mouth habits (finger/thumb sucking, lip biting, etc.)? ☐ Yes ☐No

If yes:
____

Has your child encountered "negative" dental or medical experience? ☐ Yes ☐No

If yes:
____

Has your child or any other member of your family, had a problem with general anesthesia? ☐ Yes ☐No

If yes:
____

Have you ever been told that your child needs antibiotics before their dental treatment? ☐ Yes ☐No
If yes:
____

Does your child have or ever had any of the following conditions?

Heart Trouble/Heart Surgery ☐ Yes ☐No	Seasonal Allergies ☐ Yes ☐No
Immune Diseases ☐ Yes ☐No	Bone or Joint problems ☐ Yes ☐No
Kidney or liver problems ☐ Yes ☐No	Cancers or Malignancies ☐ Yes ☐No
Autism/ Spectrum Disorder ☐ Yes ☐No	Asthma ☐ Yes ☐No
Diabetes ☐ Yes ☐No	ADHD ☐ Yes ☐No
Mental Disorders ☐ Yes ☐No	Blood Disorders ☐ Yes ☐No

Does your child have or ever had any serious illnesses not listed above? ☐ Yes ☐No

If yes: ____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

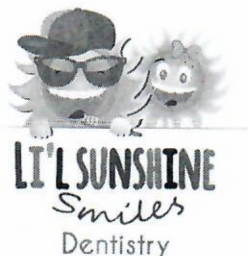
____ Date: ____________________
Signature of Doctor or Provider

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ____________________

Name of person or office referring you to our practice: ______________________________



Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

SS#/SIN: ____________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ____________

Address: ____________________
Street Apartment #

____
City State/Province Zip/Postal Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ Occupation: ____________________

Address: ____________________
Street City, State/Province Zip/Postal Code Phone

Insurance Information

Primary

Name of Insured: ____________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____________________
Street City State/Province Zip/Postal Code

Insured's Employer Name: ____________________

Address: ____________________
Street City State /Province Zip/Postal Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____________________

____

Secondary

Name of Insured: ____________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____________________
Street City State/Province Zip/Postal Code

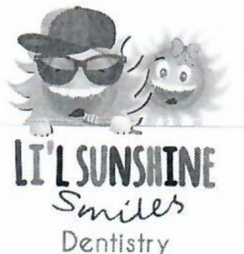
Insured's Employer Name: ____________________

Address: ____________________
Street City State/Province Zip/Postal Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____________________

____



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 01/23/2020 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.

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.

HIPPA PRIVACY POLICY
Confirmation of Policy Review

By signing this form you acknowledge that you have seen this HIPPA Privacy Policy and that you have read all of the HIPPA Privacy Policy and that you understand the HIPPA Privacy Policy.

Adult patient, Parents and Legal Guardians reviewing this HIPPA Privacy Policy please print your name, sign and date below:

Print: Patient/Parent/Legal Guardian________________________________ Date: ________________.

Signature: Patient/Parent/Legal Guardian____________________________ Date: ________________.

Li'l Sunshine Smiles Dentistry may discuss my information with the following:

NAME	RELATIONSHIP
________________________________	________________
________________________________	________________
________________________________	________________

Li'l Sunshine Smiles Dentistry

My Staff and I would like to welcome you and your child to our practice. We believe in creating vibrant and healthy smiles using the most advanced quality dentistry to exceed our patients' expectations. Beginning with the overall health of your child's mouth, we can provide your child with the smiles he or she needs. We would like to provide you with information to make our patients experience more comfortable.

Office Hours:

Monday	8:30 am – 5:00 pm
Tuesday	9:00 am - 6:00 pm
Wednesday	8:30 am – 5:00 pm
Thursday	10:00 am – 7:00 pm
Friday	8:30 am - 5:00 pm

Financial Policy:
We accept Visa, Mastercard, Discover and American Express.

We will be happy to file your insurance and accept assignment of benefits. However you are ultimately responsible for all charges that are incurred. We will do our best to facilitate payment from your insurance company. We ask that you pay your portion at the time of service unless prior financial arrangements are made. A finance charge of 1 ½% per month may be levied on all balances over 90 days.

We work with Care Credit to give you greater financial arrangement opportunities.

Cancellations:
Each appointment is made especially for you; we try to accommodate your schedule by giving you a choice of appointment times. We respect your busy schedule by seeing and finishing your procedures in a timely manner. We ask that you give us 24 hours notice to cancel your appointment. A $30 charge may be billed in the event of a Broken Appointment or a cancelled appointment that was not cancelled 24 hours prior to the appointed time.

Our staff will be more that happy to answer any other questions that you may have.

Sincerely,

Dr. Catalina Botero

____
Patient/Guardian

Date: ____________

12950 Racetrack Rd
STE 109 Tampa, FL
33626
813-803-3355