TURKE ADVANCED TADA DENTAL ARTS

1201 SW Sunset Trail
Palm City, FL 34990
772-919-7444

Chart #:_____
FOR OFFICE UUSE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birthdate: _____ Driver's License #_____ State_____

Phone: Home (____)_____ Cell (_____)_____ Work (_____)_____ Ext:_____

Home Street Address: _____
Street *Apartment #*

City, State Zip _____ Email_____
City State Zip Code

Health Information

Date of Last Dental Visit/Cleaning: _____ Reason for this visit: _____

Have you ever had any of the following? Please read this carefully and circle Y for Yes and N for No:

AIDS/HIV	Y N	Heart Murmur, Functional	Y N	Stomach Problems	Y N	Aspirin Allergy	Y N
Anemia	Y N	Hepatitis A B or C	Y N	Stroke	Y N	Codeine Allergy	Y N
Artificial Joints	Y N	High Blood Pressure	Y N	Taking Blood Thinner	Y N	Latex Allergy	Y N
Asthma	Y N	Jaundice	Y N	Thyroid Disorder	Y N	Penicillin Allergy	Y N
Auto Immune Disorder	Y N	Kidney Disease	Y N	Tuberculosis	Y N	Other Allergies_____	
Cancer_____	Y N	Liver Disease	Y N	Tumors/Cysts	Y N	OTHER:	
Diabetes	Y N	Mental Disorders	Y N	Ulcers	Y N	☐ _____	
Epilepsy	Y N	Pacemaker	Y N	Venereal Disease	Y N	Smoker	Y N
Excessive Bleeding	Y N	Pregnant	Y N	Other	Y N		
Fainting	Y N	Due Date: _____		Explain:_____			
Head Injuries	Y N	Respiratory Problems	Y N	**ALLERGIES:**			
Head-Neck Radiation	Y N	Rheumatic Fever	Y N	Anesthetic Allergy	Y N		
Heart Disease	Y N	Sinus Problems	Y N	_____			

Office Use Only
☐ Pre-Medicate ☐ No Epinephrine
Dr/RDH_____

- What medications, vitamins, or herbal remedies are you taking at this time? _____
  _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone:_____
- Whom may we contact in the event of a medical emergency? Name: _____
  Relationship to patient: _____ Phone: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- What are your expectations from this office? _____
- Do you have any dental concerns? ☐ Yes ☐ No If yes, explain _____
- Have you had periodontal treatments in the past? ☐ Yes ☐ No If yes, explain _____
- Do you have frequent headaches? ☐ Yes ☐ No Do you clench or grind your teeth? ☐ Yes ☐ No
- Are you interested in: ☐ Whitening ☐ Invisalign ☐ Veneers
- Do you like your smile? ☐ Yes ☐ No What changes would you like to make to the appearance of your teeth? _____
  _____
- Have you ever had Nitrous Oxide(laughing gas)? ☐ Yes ☐ No Would you like Nitrous oxide for dental treatment? ☐ Yes ☐ No

To the best of my knowledge, all of 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.

X Signature of patient, parent or guardian_____ Date:_____

PERMISSION TO DENTISTS/HYGIENISTS -- I give my consent to use local anesthetic or relaxants for completing necessary dental treatment.

X Signature of patient, parent or guardian_____ Date:_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Patient ☐ Friend/Relative ☐ Facebook ☐ Internet ☐ Other: _____

Name of person, office, or internet site referring you to our practice:_____

Patient Employment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Employer Phone: _____

Insurance Information

Name of Insured:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #: _____ Insured Birth Date: _____

Insurance Company Address: _____

City, State, Zip: _____ Phone: _____ Rem Benefits:_____ Rem Deductible: _____

Employer Name: _____ Occupation: _____

Street, City, State, Zip _____

Consent for Services

As a condition of your treatment by this office, all emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed. The practice depends upon reimbursement from the patients for the costs incurred in their care. As a condition of your treatment by this office, services are to be paid when rendered, or definite financial arrangements must be made and approved by Turke advanced Dental Arts prior to commencement of treatment.

During the course of dental treatment, I may undergo procedures in all phases of dentistry including periodontics, oral surgery, endodontics, fixed and removable prosthodontics, implant surgery, restorative dentistry, TMJ disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health. No guarantees can be made about treatment outcomes, restoration longevity or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

Every effort is made to inform you of your account balance. Our office mails monthly statements and makes courtesy phone calls in an attempt to collect any owed balances. We instill the help of an outsourced collection agency once we have exhausted our efforts to contact your balance that remains after 90 days.

In consideration for the professional services rendered to me, by Turke Advanced Dental Arts, I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my dental treatment. **Initial**_____

REGARDING MISSED OR CANCELED APPOINTMENTS: Once I make an appointment, the time will be reserved for me. If I miss two or more appointments, or cancel a dental appointment **without 24 hours advance notice**, I agree to pay **$40 PER HOUR OR $40 PER APPOINTMENT depending on appointment length** for the appointment time reserved. This policy is needed to prevent delays of my treatment as well as other patients. I realize that the delay of a missed or cancelled appointment may jeopardize my dental health. **Initial**_____

DEPOSITS: Patients must pay a deposit in order to reserve an appointment for major restorative work. Most procedures that fall within this category are root canals, crowns, bridges, partials, and/or operative appointments that will require 1 ½ hours of time or more. The deposit required is **50-75% of the total patient estimated cost**. The deposit will be applied to total treatment cost on the day of service and is ***non-refundable*** within the cancellation policy or if patient declines treatment. I**nitial**_____

I have read the above conditions of treatment and payment and agree to their content.

X Signature of patient, parent or guardian_____ Date: _____ Relationship to Patient: _____

X Signature of guarantor of payment/responsible party_____ Date: _____ Relationship to Patient: _____

Hygiene Treatment

There are several procedures that can be classified as "cleanings". The hygienist or doctor will do a periodontal chart as well as evaluate your radiographs in order to diagnose what cleaning you will need. We will present you with a treatment plan of the procedure and estimated cost of your recommended treatment before any procedure is performed.

- **Prophylaxis (D1110)** : A routine cleaning of the teeth for the patient with healthy gingiva (gums). Procedure includes removal of plaque, calculus and stains from above the gum line. Note: Healthy gums DO NOT bleed.

- **Debridement (D4355**) : This cleaning is used to treat gingivitis and conditions where inflammation and infection exist. Procedure includes the gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This is a preliminary procedure that does not exclude the need for additional procedures.

- **Scaling with Gingival Inflammation (D4346):** This procedure is the removal of plaque, calculus & stains from supra& sub gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. Patients who have swollen or inflamed gingiva, general supra-bony pockets and moderate to severe bleeding in probing.

- **Periodontal Scaling & Root Planning (D4341 or D4342):** This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is performed for patients with periodontal disease and is therapeutic, not prophylactic. Root planning is a procedure performed to remove toxins and microorganisms. It may be used as definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in others.

- **Periodontal Maintenance (D4910**): This procedure follows the Periodontal Scaling & Root Planning at varying intervals, for the life of the dentition or any implants. It includes removal of the bacterial plaque and calculus from above & below the gum line, specific scaling where indicated and polishing of the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedure may be considered including consulting with a Periodontal specialist.

- **Local Delivery of antimicrobial Agents (D4381**): FDA Approved antibiotic placed directly into the infected areas (pockets) in your gums. It is applied right after scaling & root planning. This antibiotic slowly releases an antibiotic called minocycline which kills bacteria that cause periodontal infection, inflammation and bleeding.

I have read the information above regarding my dental hygiene treatment.

Date: _____ Patient _____

Oral Cancer Screening Consent

Our practice continually looks for advances to ensure we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient. One person dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor of oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors.

Oral cancer risk by patient profile is as follows:

- **Increased Risk**: patients ages 18-39
- **High Risk**: patients age 40 and older; tobacco users (any age, any type within 10 years)
- **Highest Risk**: patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use): previous history of oral cancer

We have incorporated **Velscope** into our oral cancer screening standard of care. We find that using **Velscope** along with a standard oral cancer examination improves the ability to identify suspicious areas at their early stages. **Velscope** is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.

The Velscope is offered to you annually.

This examination is recognized by the American Dental Association code revision committee as D0431, however this exam might not be covered by your insurance plan. **The fee for this exam is $20.00.**

Patient Name: _____ Date: _____

Yes, I authorize TADA to perform the Velscope oral cancer screening exam along with the standard oral examination and/or cleaning. I accept financial responsibility for this examination.

Signature: _____

No, I elect to not have my oral cancer screening at this time.

Signature: _____

Turke Advanced Dental Arts

Andrew L. Turke D.M.D

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 04/14/2003, and will remain in effect until we replace it.

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

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

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

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

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

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to any one 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 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 any 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 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)

PATIENTS 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 reasonably 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, $15.00 per hour of 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 full explanation of our fee structure.)

DISCLOSURE OF 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 14th, 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 emergencies).

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 A REQUEST IN WRITING}. Your request must specify the alternate 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 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 website or by 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 bottom 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 Human Services upon request.

We support your right to 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: Dr. Andrew L. Turke D.M.D

Phone: (772) 919-7444 FAX- (772) 365-2297

Signature of Patient, Parent or Guardian: _____ Date: _____

HIPPA

ACKNOWLEDGMENT OF RECEIPT AND GENERAL CONSENT

I acknowledge that I received a copy of the Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment, and health care operations & as authorized or required by law under the circumstances describes in the Notice of Privacy Practices.

Date: _____

Patient Name: _____

Signature: _____

Relationship to Patient: _____

FOR PATIENTS WHO ARE 18 YEARS OF AGE OR OLDER

I give permission to those listed below to have access to my medical information and to discuss matters relating to my care. I recognize that if I do not list anyone below, I am the only person who will have access to information regarding my medical information and care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Print Name: _____ Date: _____

Signature: _____

Permission to Use Photograph

I grant to *Turke Advanced Dental Arts*, its representatives and employees the right to take photographs of me.

I authorize *Turke Advanced Dental Arts* to copyright, use and publish the same in print and/or electronically.

I agree that *Turke Advanced Dental Arts* may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content including social media outlets such as Facebook, Instagram and Twitter.

_____Yes, you may use my photograph.

OR

_____No, please do not use my photograph.

Patient Signature _____

Patient Printed name _____

Signature, parent or guardian _____
(if patient is under age 18)