



Welcome, to Steven H. Feit Dental Happiness (Your new Dental Home)

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
I would prefer to be called " \_\_\_\_\_ " by Dr. Feit and his team.

Phones: Cell Phone: ( \_\_\_\_\_ ) Home Phone:( \_\_\_\_\_ )  
Work Phone: ( \_\_\_\_\_ ) Fax Phone: ( \_\_\_\_\_ )

Email Address: \_\_\_\_\_ @ \_\_\_\_\_ . (Never Shared)  
Florida Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

We use a special system with you to provide appointment reminders. Which is your preferred way of receiving this information (you may check more than one, as many as you wish):  Text,  Email,  Phone message.

Whom may we thank for referring you? \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age Now: \_\_\_\_ Years \_\_\_\_ Social Security #: \_\_\_\_\_  
Marital status:  Single  Married  Divorced  Widowed Spouse's Name: \_\_\_\_\_  
 Significant other: Significant Other's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Emergency Contact Information

In case of EMERGENCY, who should we call? Name: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ )  
Home Health Aid: Name: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ )  
Nearest relative/friend not living with you? Name: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ )  
Who is Responsible for this account: \_\_\_\_\_ Drivers License \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ )

### Medical History

Name of personal physician: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) - \_\_\_\_\_  
Last visit with Physician: \_\_\_\_\_ Current Health:  Excellent  Good  Fair  Poor

\*\*\*\*\*If you are taking Birth Control medications you must know that if you ever take antibiotics the birth control medication will no longer work, you will be at risk for becoming pregnant. x \_\_\_\_\_ Initial here.

Are you currently taking any medications?  Yes  No. If yes, please list below:

<i>Name of Medication</i>	<i>Purpose</i>	<i>Name of Medication</i>	<i>Purpose</i>
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Have you experienced?

Yes No **DO YOU NEED TO PREMEDICATE PRIOR TO YOUR DENTAL TREATMENT**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain (angina)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Ankles?           | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath?                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Recent weight loss?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Persistent cough?         | <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding problems, bruising easily? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus problems?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty swallowing?    | <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea, blood stools?             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent vomiting, nausea?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty urinating?     | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems?                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in the ears?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Diseases?                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred vision?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive thirst?                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent urination?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Dry mouth?                | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice?                           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Joint pain, stiffness?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease?            | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung Diseases?                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke? When:                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure?   | <input type="checkbox"/> Yes <input type="checkbox"/> No TB, Emphysema?            | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attacks? Defects?             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis? A, B or C?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach problems?         | <input type="checkbox"/> Yes <input type="checkbox"/> No Family history of Diabetes?Who:     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS or ARC?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis, Rheumatism?    | <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness? When:                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia, blood diseases?  | <input type="checkbox"/> Yes <input type="checkbox"/> No VD (Syphilis, Gonorrhea)? | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures? Last:                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney or bladder disease?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches? When:                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric care?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthetic Heart valve?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial joint? Which:            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Contact lenses?           | <input type="checkbox"/> Yes <input type="checkbox"/> No Recreational drugs?                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin taken regularly?   | <input type="checkbox"/> Yes <input type="checkbox"/> No Reaction to "novocaine"?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting Spells? When:              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Smoke/Chew Tobacco?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Women: Are you pregnant?  | <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Sleeping? Apnea? Snore?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer Treatments: Where: _____ Location on Body: _____ When: _____      |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy Treatment: Where: _____ Location on Body: _____ When: _____ |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatment: Where: _____ Location on Body: _____ When: _____    |  |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric care? When: _____ Diagnosis: _____ Last session: _____       |  |  |

Allergies to:  Penicillin  Erythromycin  Aspirin  Dental Anesthetic  Codeine  Other: \_\_\_\_\_  None

**Please explain if you have been treated for any other illnesses not listed above?**

### Dental History

What is your reason for visiting with us today? What are your goals with respect to your dental, oral condition?

How would you describe the conditions of your mouth, teeth and gums?  Good  Fair  Poor

Are your teeth sensitive to  hot  cold  sweets  biting pressure  just comes on by itself (Where?) \_\_\_\_\_

- Yes No Are you in pain now? (If yes, explain): \_\_\_\_\_
- Yes No Does your bite feel "off"; are your teeth hitting harder, more in one area, do you hit and then slide?
- Yes No Pain in your jaw joint or ears? Headaches? Ear Aches?
- Yes No Do your gums bleed when you floss or brush?
- Yes No Do you have dry mouth?
- Yes No Have your teeth shifted?
- Yes No Do you grind your teeth?
- Yes No Do you get "fever blisters"? \_\_\_ Lips? \_\_\_ Inside mouth?
- Yes No Do you have an unpleasant taste or odor?
- Yes No Do you wear a nightguard? How long \_\_\_ yrs. If yes, (circle one please:) Upper or Lower
- Yes No Have you experienced pain in your jaw joint or has your jaw ever locked open or closed?
- Yes No Do you get frustrated because you always have something treated or repaired when you visit the dentist?
- Yes No Do you get headaches? Any kind of headaches? Describe: \_\_\_\_\_
- Yes No Does/did your Jaw click or pop? If yes, do you still have it or did it go away? \_\_\_\_\_
- Yes No Have you ever been treated for TMJ symptoms? (If yes, please explain): \_\_\_\_\_

**What is most important to you?**  The highest quality dentistry available  The most economical treatment plan  A combination of the above

What is your time frame, when would you like to begin? \_\_\_\_\_

 \_\_\_\_\_ Date: \_\_\_\_\_

# Welcome

Steven H. Feit, D.M.D., P.A.

This information will help us transition your care and treatment and help maintain optimum communication with your team:

Previous/Current Northern Dentist:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Previous/Current Periodontist:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Previous/Current Oral Surgeon:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Previous/Current Endodontist:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Previous/Current Orthodontist:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

I understand that the information is correct to the best of my knowledge. I understand it will be held in the **strictest confidence** and only be used to improve communication between the Doctor and myself. I understand that I am inducing/authorizing Dr. Steven H. Feit to perform professional services on my behalf and agree to be financially responsible for all expenses incurred and charged as a result of Dr. Steven H. Feit rendering professional services, including *all* costs of collection associated therewith, including court costs and attorney's fees. In case of suit, you agree the venue shall be Boca Raton, FL, Palm Beach County. (We are proud to say that this has not become an issue ever, since 1983. I also authorize disclosure of my record to the extent necessary to determine liability for payment and (to insurance companies etc). I also give permission for the Doctor to disclose my information with associated Doctors also rendering treatment for me, (associated physicians and dentists with Doctors whom have previously rendered treatment on my behalf). I also give permission for the Doctor or his staff to use any photos he may take to be used for lecturing and educational purposes with every effort made to protect and hide my identity.

**Our Privacy Notice:**

We are committed to maintaining the confidentiality, integrity and security of personal information entrusted to us by current and prospective clients. We want you to know how we protect your information and how we use it to service you. Please take a moment to review our Privacy Policy. We do not share any nonpublic personal information about you with any third parties except as necessary to assist you with your insurance needs, to coordinate and sequence your treatment with other associated specialists/generalists you have authorized to participate in your care and treatment or except as required by law. We restrict access to your personal information to those employees who need to know this information to provide the highest level of care and treatment for you. In addition, you can feel comfortable knowing we maintain physical and procedural safeguards to protect your personal information.

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



Date: \_\_\_/\_\_\_/\_\_\_ Thanks for your time to fill this out.

# NOTICE OF PRIVACY PRACTICES

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**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.**

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## **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 December 22, 2002, 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.

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## **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).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0 for each page, \$0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Steven H. Feit, D.M.D.

Telephone: 561-338-7535 Fax: 561-368-2981

E-mail: [smilespecialist1@gmail.com](mailto:smilespecialist1@gmail.com)

Address: 240 West Palmetto Park Rd, Ste 220, Boca Raton, FL 33432

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