Samuel V. Rowe, D.M.D., P.A.
605 Citrus Avenue
Fort Pierce, FL, 34950

Patient Name: ______________________________ Date: ______________
Date of Birth: __________________ Please circle one: Single Married Other:________
Address: ____
City: ______________________ State: ____________ Zip Code: __________
Home #: ________________ Cell #: __________________Other: __________
Email Address: ____
Dental Insurance: _________________________ SS#: _____-_____-_____
Referred by: ______________________________

Chief Oral Complaint: ____
Date of last dental exam: ____________________
Are you having any dental discomfort at this time? Y☐ N☐ If yes, please explain:

____

Have you ever had serious trouble with dental work? Y☐ N☐ If yes, please explain:

____

Have you ever had any abnormal bleeding associated with previous extractions, surgery, or trauma? Y☐ N☐ If yes, please explain:

____
How often do you brush your teeth? ______________ Floss? ______________
Do you use tobacco? Y☐ N☐
Do you use alcohol? Y☐ N☐
Do you have any current/past history of substance abuse? Y☐ N☐

Are you allergic to anything? Y☐ N☐

Allergy: Reaction:
1.____
2.____
3.____
4. ____

Medical:

Have there been any major changes to your health within the past year? **Y□ N□**
If yes, please explain: ______________________________
Are you under the care of a physician or are you receiving ongoing medical care? **Y□ N□**
If yes, please explain: ______________________________
Name of physician: ______________________ Phone #: ______________

Do you have any artificial joints, heart valves, implants or prosthesis? Y□ N□
Explain: ______________________________
Have you had surgery, x-ray treatment or chemotherapy for a tumor, growth, or other condition? **Y□ N□**
Explain: ______________________________

Y□N□ Pregnant
Y□N□ High blood pressure
Y□N□ Heart attack
Y□N□ Heart murmurs
Y□N□ Other heart problems
Y□N□ Diabetes
Y□N□ Thyroid problems
Y□N□ Hay fever
Y□N□ Shortness of breath
Y□N□ Persistent cough
Y□N□ Positive test/treatment for tuberculosis
Y□N□ Seasonal allergies
Y□N□ Emphysema
Y□N□ Coughing up blood
Y□N□ Hep A, B, or C
Y□N□ Liver disease
Y□N□ Numbness of arms,legs,hands or feet?
Y□N□ Joint/Back pain
Y□N□ History of broken bones
Y□N□ Arthritis
Y□N□ Stomach pain
Y□N□ Heartburn
Y□N□ History of ulcers
Y□N□ Colitis
Y□N□ Depression
Y□N□ Anxiety
Y□N□ Epilepsy/Seizures
Y□N□ History of head injury
Y□N□ History of stroke
Y□N□Fainting spells
Y□N□ Bleeding problems
Y□N□ Anemia
Y□N□ Immune system disorders
Y□N□ Kidney or bladder problems

Do you have any other disease, condition or problem not listed? **Y□ N□**
If yes, please explain:

Medications:

Name: Dosage: Reason for use:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

General Informed Consent:

I, ________________________________, consent to necessary diagnostic treatment provided by Dr. Samuel V. Rowe. Including, but not limited to, diagnostic tests, cleanings, x-rays, exams and any other procedure that is deemed necessary.

____

Patient Signature

____

Date

Notice of Privacy Practices

Faxing and Emailing Rule- When you request us to fax or e-mail your PHI (personal health information) as alternative communication and we agree to do so. We may fax or e-mail super confidential information, we will not fax or e-mail for emergency communication without knowing the recipient is expecting the message; have only our privacy officer or your treating doctor fax or e-mail your PHI; have our privacy officer confirm receipt; locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so the PHI is not the first page to print out (because unauthorized persons may view the top page) and attach an appropriate privacy notice to the message.

Practice Transition Rule- If we sell our practice, our patient records (including but not limited to your PHI) may be disclosed and physical custody may be transferred to the purchasing doctor, but only in accordance with the law. The doctor who is the new records owner will be solely responsible for ensuring privacy of your PHI after the transfer and you agree that we will have no responsibility for (or duty associated with) transferred records. If all the owners of our practice die, our patient's records (including but not limited to your PHI) must be transferred to another doctor within 90 days to comply with Florida Board of Dentistry Rules and FLA Admin Code. Before we transfer records in either of these two situations, our privacy officer will obtain a Business Associate Agreement from the purchaser and review your PHI for super confidential information
(E.g. HIV/AIDS records) which will not be transferred without your express written authorization (indicated by your initials on our consent form).

Inactive Patient Records- We will retain your records for seven years from your last treatment or examination at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighth birthday). We will do so only in accordance with the law.

Collections and Marketing- If we use or disclose your PHI for marketing (I.e. communications that encourage recipients to purchase or use a product or service) or collections purposes, we will do so only in accordance with the law.

Acknowledgement of receipt of NOTICE OF PRIVACY PRACTICES:

Received this day _______________ of ___________________, 20___

Patient's signature____

HIPAA- Patient Consent Form

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The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created to provide a standard for certain healthcare providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment of health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that interact with doctors and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following:

A. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment; I.e. release of radiographs and or treatment plans to referring physicians and or dentists).
B. Obtaining payment from third party payers (I.e. my insurance company)
C. The day-to-day healthcare operations of your practice.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Name: ______________________________

Signature: ______________________________ Date: ________________

Parent/ Guardian: ______________________________