MOGELL DENTAL ASSOCIATES
2900 N. MILITARY TRAIL
SUITE 212 - SOUTH BUILDING
BOCA RATON, FL 33431
561-394-9000

Name_____Date_____

Address_____

City_____State_____Zip_____

Home Phone_____Cell_____Work_____

Email Address_____

Emergency Contact_____

Date of Birth_____Social Security Number_____

Physician Name_____Phone_____

Are you taking prescription/over the counter medications? Yes No

Medication Names_____

Do you take blood thinners? Yes No Are you taking Biphosphinates Yes No

Do you require premedication? Yes No Women: Are you pregnant? Yes No

Do you have allergies? Yes No Please list_____

Do you have a history of chemical dependency? Yes No How long in recovery?_____

Have you ever had or are you being treated for:

High Blood Pressure	Yes	No	Sinus Problems	Yes	No
Heart Attack	Yes	No	Asthma	Yes	No
Heart Murmur	Yes	No	Surgical Shunts/Pins/Plates	Yes	No
Artificial Heart Valve	Yes	No	Artificial Joints/Implants	Yes	No
Pacemaker	Yes	No	Kidney Disease	Yes	No
Congestive Heart Disease	Yes	No	Thyroid Disease	Yes	No
Stroke	Yes	No	Arthritis	Yes	No
Anemia	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Hepatitis	Yes	No
Diabetes	Yes	No	GERD	Yes	No
Epilepsy	Yes	No	Glaucoma	Yes	No
TB or Lung Disease	Yes	No	Cancer/Radiation Therapy	Yes	No
Ulcers	Yes	No	HIV/AIDS	Yes	No
Stomach Problems	Yes	No	Hemophilia	Yes	No

Have you ever experienced any of the following?

Clicking in your Jaw	Yes	No	Participation in a sleep study	Yes	No
Pain in or around ears	Yes	No	Diagnosed with sleep apnea	Yes	No
Periodontal treatment	Yes	No	Do you use a CPAP machine	Yes	No
Difficulty in chewing	Yes	No	Do you snore	Yes	No
Difficulty opening or closing	Yes	No	Diagnosis of TMJ/TMD	Yes	No
History of jaw trauma	Yes	No	Have you had periodontal treatment	Yes	No

Who may we thank for referring you?_____

I have reviewed the above questionnaire and find it accurate and complete. I understand this information will be used by the doctors to determine appropriate treatment. A treatment plan with explanation will be presented to me before treatment is rendered. I give Dr. Mogell/Dr. Epstein consent to perform this treatment. I understand I am fully responsible for all charges related to any treatment incurred by me. Balances not paid within 30 days will be subject to a 1.5% service fee and will be subject to legal and collection fees.

Date_____Signature_____

MOGELL DENTAL ASSOCIATES
2900 N. MILITARY TRAIL
SUITE 212 - SOUTH BUILDING
BOCA RATON, FL 33431
561-394-9000

Medication Log

Because many people cannot recall details of prescriptions or over-the-counter medications at the doctor's office, we ask that you complete this form to bring to your appointment. Please ask any notes or comments at the bottom of this form concerning any allergies you may have to medications. You may wish to list those you have tried with adverse affects or that were unhelpful.

Patient Name:_____Date:_____

1._____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Check if list is attached _____

Doctors List

To better coordinate your treatment, it is required that you list the professionals including all physicians, dentists, and therapists that you have consulted concerning your present symptoms. In addition, please list your general physician and family dentist. If your symptoms are a result of an accident and you are working with an attorney, please list that attorney as well.

Family Physician_____ Family Physician_____

Address _____ Address _____

_____ _____

Phone _____ Phone _____

Referring Doctor_____ Other _____

Address _____ Address _____

_____ _____

Phone _____ Phone _____

I understand that the professionals I have listed may be sent information regarding my diagnosis and treatment.

Check if list is attached _____

MOGELL DENTAL ASSOCIATES
2900 N. MILITARY TRAIL
SUITE 212 - SOUTH BUILDING
BOCA RATON, FL 33431
561-394-9000

Insurance Intake

Patient name: _____

Subscriber Name: _____D.O.B._____

Relationship to subscriber (if not self): _____

Subscriber ID: _____

Effective dates: _____/_____/_____ to _____/_____/_____

Employer: _____

Carrier: _____

Carrier phone number: _____

Carrier address: _____

Group name: _____

Group number: _____

You are responsible for any deductibles and/ or co-pays your insurance does not cover. Please remember to bring your insurance card, photo ID, and any other necessary cards to your appointment. You are responsible for informing our office of insurance changes as they occur.

Confirmation/ Cancellation Policy

Upon scheduling an appointment at our practice, it becomes **your responsibility** to keep your appointment. An appointment is an agreement by us that we will be on time and ready for you when you arrive and also that you will be on time for your appointment. If you must change an appointment, we request a minimum of **48 hours** notice. We will give you a courtesy reminder either by text message, email or phone prior to your appointment. We require each and every patient to confirm their appointment via phone, fax or email during our normal business hours.

Broken appointments with less than 48 hours notice will be subject to a cancellation fee. We require all cancellation fees to be paid in full prior to being rescheduled for any future appointments. Thank you for your kind understanding.

*****In order to provide you with the highest level of confidential and professional service with the least intrusion; please choose your preferred methods of confirming your appointments at our office.**

_____ _____ _____

Email Yes ☐ No ☐ **Telephone** Yes ☐ No ☐ **Text** Yes ☐ No ☐

Thank you for your help and your loyalty to our practice!

Acknowledgement of Receipt of Privacy Practices

I have received a copy of the "Notice of Privacy Practices" from Mogell Dental Associates.

Signature: _____ **Date:** _____

Refused to sign: _____
Communication barriers prohibited obtaining the acknowledgement _____
An emergency situation prevented us from obtaining acknowledgement_____

I grant the following people permission to share in my treatment and or billing information:

1._____ 2._____

Authorization for Dental Treatment and Assumption of Financial Responsibility

I, _____, authorize Mogell Dental Associates to treat

_____. (Patient name or name of minor and relationship)

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic as indicated and I hereby assume responsibility for fees associated with those procedures. I understand that if I request my dental record via email it will be sent through an unencrypted email.

Please be aware that medical insurance is not a guarantee of payment. All services rendered are the responsibility of the patient.

All accounts 30 days past due will be subject to a 1.5% service fee monthly and may also include legal and collection costs if required.

Signature **Date**

MOGELL DENTAL ASSOCIATES
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 (07/09/2010), 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. 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 $0.25 for each page, $25 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: Annette Mogell

Telephone: (561)394-9000

E-mail: drmogell@drmogell.com

Address: 2900 North Military Trail, Suite 212, Boca Raton, FL 33431