NEW PATIENT INFORMATION

Complete all applicable fields. Write N/A when not applicable.

PATIENT INFORMATION

Full legal name		**Preferred name**	
Date of birth		**Gender (optional)**	
SSN (optional)		**Marital status**	
Referral source		**Referred by**	
Employer		**Occupation**	

CONTACT INFORMATION

Mobile phone		**Home phone**	
Email		**Preferred contact method**	
Street address		**City**	
State		**ZIP code**	

EMERGENCY CONTACT

Full name		**Relationship**	
Phone		**Alternate phone**	

RESPONSIBLE PARTY / GUARANTOR (IF DIFFERENT)

Name		**Relationship**	
Address		**Phone**	

I certify that the information provided is accurate and complete to the best of my knowledge. I will notify the office of changes to my contact, insurance, or health information.

Patient / Representative signature _____ **Date** _____

MEDICAL & DENTAL HEALTH HISTORY

Patient name: _____ DOB: _____

Answer each question accurately; mark Yes or No and provide details as needed.

GENERAL MEDICAL QUESTIONS

Are you under a physician's care? Physician/name/phone:	**Yes☐ No☐ Details:**
Have you had serious illness, hospitalization, or surgery?	**Yes☐ No☐ Details:**
Are you taking prescription/OTC medicines, vitamins, or supplements? List:	**Yes☐ No☐ Details:**
Have you taken Fosamax, Boniva, Actonel, or other bisphosphonates?	**Yes☐ No☐ Details:**
Any allergies to medicines, latex, foods, or other substances? Reaction:	**Yes☐ No☐ Details:**
Any adverse reaction to dental anesthetic or medication?	**Yes☐ No☐ Details:**
Do you smoke, vape, use tobacco, or recreational drugs?	**Yes☐ No☐ Details:**
Do you consume alcohol?	**Yes☐ No☐ Details:**
Pregnant, possibly pregnant, or nursing (if applicable)?	**Yes☐ No☐ Details:**
Bleeding disorder or use of blood thinners?	**Yes☐ No☐ Details:**
Heart condition, pacemaker, artificial valve or joint?	**Yes☐ No☐ Details:**
Have you been advised to take antibiotics before dental care?	**Yes☐ No☐ Details:**

MEDICAL CONDITIONS — CHECK ANY THAT APPLY

Alzheimer's/dementia☐ Anemia☐ Anaphylaxis☐ Angina☐ Arthritis/gout☐ Artificial heart valve☐ Artificial joint☐ Asthma☐ Cancer☐ Blood disease/bleeding disorder☐ Blood pressure high/low☐ Breathing problems☐ Bruise easily☐ Cardiovascular disease/heart attack☐ Chest pain☐ Congenital heart disorder☐ Cortisone/steroid medicine☐ Diabetes☐ Substance use disorder☐ Emphysema☐ Epilepsy/seizures☐ Excessive bleeding/bruising☐ Frequent diarrhea☐ Frequent headaches☐ Genital herpes/herpes☐ Glaucoma☐ Hay fever/allergies☐ Heart murmur☐ Heart disease☐ Hepatitis A/B/C☐ High cholesterol ☐

HEALTH HISTORY — CONTINUED

Patient name: _____ DOB: _____

Hypoglycemia ☐ Kidney problems/dialysis ☐ Liver disease ☐ Lung disease ☐ Mitral valve prolapse ☐ Osteoporosis ☐ Radiation treatments ☐ Recent weight loss ☐ Rheumatic fever/rheumatism ☐ Scarlet fever ☐ Shingles ☐ Sickle cell disease ☐ Sinus trouble ☐ Stomach/intestinal disease ☐ Stroke ☐ Thyroid disease ☐ Tuberculosis ☐ Tumors/growths ☐ Venereal disease/STI ☐ Other serious illness not listed ☐

ADDITIONAL DETAILS / DIAGNOSES / DATES

_____

_____

_____

I have disclosed all health conditions, medications, allergies, and relevant history known to me. I understand inaccurate or incomplete information may affect care. I will notify the office of changes.

Patient signature confirming health history _____ **Date** _____

Dentist review / notes: _____

DENTAL HISTORY & REVIEW

Patient name: _____ DOB: _____

DENTAL HISTORY

Last dental visit: _____ Last cleaning: _____	**Yes☐ No☐ Details:**
Primary dental concern / reason for visit:	**Yes☐ No☐ Details:**
Pain, sensitivity, swelling, or bleeding gums?	**Yes☐ No☐ Details:**
Prior periodontal treatment, root canal, extraction, implant, or oral surgery?	**Yes☐ No☐ Details:**
Grind/clench teeth or wear nightguard?	**Yes☐ No☐ Details:**
Problems with dental treatment or anesthesia?	**Yes☐ No☐ Details:**
Dentures, partials, retainers, or orthodontic appliances?	**Yes☐ No☐ Details:**
Concerned about appearance of teeth or smile?	**Yes☐ No☐ Details:**

ACKNOWLEDGMENT

I reviewed my answers and understand that my health history is important to safe treatment. I have had the opportunity to ask questions.

Patient / Representative signature _____ **Date** _____

Dentist signature: _____ Date: _____

FINANCIAL POLICY & PAYMENT AGREEMENT

Please read carefully and sign before treatment.

INSURANCE & ESTIMATES

Insurance is a contract between you and your insurer; the practice is not a party to it. Eligibility checks, pre-authorizations, and estimates are not guarantees of payment. Coverage and claim decisions are made by your plan. You remain responsible for all charges, including non-covered services, denials, deductibles, limitations, and balances.

PAYMENT RESPONSIBILITY

Payment is due at the time of service unless a written arrangement is approved in advance. Estimated copayments and deductibles are due at the visit. You are responsible for fees for services provided, including any balance not paid by insurance.

CLAIMS & PATIENT COOPERATION

The office may submit claims as a courtesy. This does not guarantee reimbursement or transfer responsibility. Provide accurate and current insurance information and requested documents. Payments received from insurers will be credited to your account.

PAST-DUE BALANCES

Past-due balances may be subject to lawful interest and collection activity, including reasonable recovery costs where permitted by applicable law. All charges and practices will comply with applicable legal limits and notice requirements.

CANCELLATIONS & MISSED APPOINTMENTS

Please give at least 48 hours' notice to cancel or reschedule. A $50 late-cancellation or missed-appointment fee may be assessed when permitted by law and disclosed in advance; this fee is not an insurance-covered dental service.

TREATMENT ESTIMATES

Treatment plans and estimates are based on information available and may change with clinical findings. The dentist will discuss material changes and obtain consent before proceeding, except where emergency care is permitted.

QUESTIONS

Contact the office promptly with questions about statements or charges so they can be reviewed. Nothing in this policy waives rights under applicable law.

I acknowledge that I have read, understand, and agree to this financial policy and accept responsibility for charges for care provided.

Patient / Representative signature _____ **Date** _____

PRIVACY PRACTICES ACKNOWLEDGMENT

HIPAA • PATIENT RIGHTS

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have been offered or received Quasha Family Dental's Notice of Privacy Practices (NPP), which describes how my protected health information may be used and disclosed and how I may exercise my privacy rights. This signature confirms receipt only and is not a blanket authorization to disclose PHI. I may request a copy of the Notice.

Patient / Representative signature _____ **Date** _____

OPTIONAL AUTHORIZATION TO DISCLOSE TO ANOTHER PERSON

Complete this section if you wish the practice to share information with a family member, caregiver, or other named person. This authorization is optional and may be revoked in writing, except for actions already taken in reliance on it.

Authorized person		**Relationship**	
Information permitted		**Purpose**	
Expiration date/event		**Phone (optional)**	

I authorize disclosure of the information specified above to the named person. I understand that the recipient may redisclose information and it may no longer be protected by HIPAA. I may revoke this authorization in writing, except for disclosures already made in reliance on it.

Patient / Representative signature _____ **Date** _____

PRIVACY AUTHORIZATION — RIGHTS & LIMITATIONS

Patient name: _____ DOB: _____

YOUR RIGHTS

You may request to inspect or obtain copies of records, request amendments or restrictions, request confidential communications, and obtain an accounting of certain disclosures, as provided by law. Contact the practice's privacy contact for instructions.

REVOCATION & REDISCLOSURE

Where an authorization is used, you may revoke it in writing unless the practice has already acted in reliance on it. Information disclosed to a recipient may be redisclosed and may no longer be protected by HIPAA.

SPECIAL PROTECTIONS

Certain records, including some substance-use-disorder records and psychotherapy notes, may be subject to additional federal or state protections and may require separate authorization. This form does not authorize disclosure of such records unless applicable requirements are met.

NO WAIVER

Nothing in this form is intended to waive rights under HIPAA, Florida law, or other applicable law. The practice will use and disclose information as permitted or required by law and its Notice of Privacy Practices.

Privacy contact: _____

Questions / comments: _____

EMAIL COMMUNICATION CONSENT

Patient name: _____ DOB: _____

PURPOSE & SCOPE

I authorize Quasha Family Dental to communicate by email about scheduling, billing, treatment coordination, and dental-related information, including PHI, at the email address provided. Email may not be encrypted end-to-end and may be accessed, forwarded, or stored by third-party providers.

RISKS & SAFEGUARDS

Email may be intercepted, misdirected, forwarded, accessed by others using my account, or stored on systems outside the practice's control. The practice uses reasonable safeguards but cannot guarantee security after sending. I will notify the office if my address changes or is no longer secure.

SENSITIVE INFORMATION

Sensitive information will be handled according to applicable law and may require separate authorization. This consent does not authorize advertising, sale of information, or unrelated disclosure.

VOLUNTARY CONSENT & WITHDRAWAL

Email consent is voluntary. I may withdraw it or request another communication method by notifying the practice. Withdrawal applies prospectively and does not affect messages already sent.

Email address		**Email use**	☐ Scheduling ☐ Billing ☐ Clinical
Alternate email		**Phone (optional)**	

I have read and understand the risks and voluntarily consent to email communication.

Patient / Representative signature _____ **Date** _____

TEXT MESSAGE (SMS) CONSENT

Patient name: _____ DOB: _____

PURPOSE & SCOPE

I authorize Quasha Family Dental to send texts to the mobile number listed below regarding appointments, reminders, billing, and care coordination. Messages may include limited health-related information. Message frequency may vary. SMS consent is voluntary and is not a condition of treatment.

RISKS

SMS is not fully secure. Messages may be viewed by anyone with access to my device, sent to a wrong or recycled number, stored or forwarded by carriers/devices. The practice uses reasonable safeguards but cannot guarantee privacy or delivery. I will keep my number current.

OPT-OUT & URGENT MATTERS

I may withdraw consent by notifying the office or replying STOP where supported. Opting out may limit reminders. Carrier message/data rates may apply. For urgent concerns, call the office; do not rely on text.

SENSITIVE / FUNDRAISING MESSAGES

Separate specific permission is required for fundraising or condition-specific outreach that uses or reveals sensitive health information. This form does not grant that permission.

Mobile number		**SMS choice**	☐ **I consent** ☐ **I do not consent**

I have read and understand the above and make my choice voluntarily.

Patient / Representative signature _____ **Date** _____

CONSENT FOR NON-COVERED TREATMENT

Patient Financial Responsibility Acknowledgment

Patient name		DOB	

Services below may be non-covered or elective under your plan. Coverage varies and is not guaranteed. Fees are practice fees. Initial only services elected after discussion with the clinician. Verify and update fees before use.

Initials	CDT / Ref.	Treatment description	Fee
	00350	Intraoral photographs — adults	$_____
	—	Full-mouth debridement (verify code/fee)	$_____
	2099	Material upgrade fee with crown procedure	$_____
	ARESTIN	Arestin — per site	$_____
	OTHER	_____	$_____

Total patient responsibility: $_____

PATIENT ACKNOWLEDGMENT

I understand that services I initialed are not represented as covered benefits and insurance may not pay. I voluntarily elect these services, had the opportunity to ask questions and discuss alternatives, and agree to pay stated fees. Material fee changes will be discussed and my agreement obtained before proceeding.

Patient / Representative signature _____ **Date** _____

Printed name: _____ Relationship: _____

Office representative: _____ Date: _____

PATIENT RECORDING CONSENT

AI-ASSISTED CLINICAL DOCUMENTATION

Patient name		Date of birth	

1. PURPOSE & SCOPE

I consent to audio recording of clinical conversations during consultations, examinations, and treatment visits for clinical documentation. Recordings may include my voice, identifiers, health history, symptoms, diagnoses, and treatment discussions. This does not authorize video or photography.

2. AI NOTES & CLINICIAN REVIEW

An AI documentation service may process audio, produce transcripts, and draft clinical notes. AI may err or omit information. My treating clinician will review and, as needed, correct documentation before finalizing it in my record. AI does not replace the clinician or independently make treatment decisions.

3. PRIVACY, PROCESSING & RETENTION

Audio may be processed by the practice's service provider and authorized providers for this purpose, with applicable safeguards and required business associate agreements. Access is limited to authorized persons. Electronic processing carries residual risk. This consent does not authorize advertising, social media, sale of recordings, or unrelated AI model training. Finalized notes are retained under applicable record-retention requirements.

4. COMPLETE BEFORE SIGNING

AI service/provider: _____
Audio/transcript retention and deletion policy: _____
Privacy contact: _____

5. CONSENT, DECLINING & WITHDRAWAL

Recording will not begin without consent. Consent is voluntary. If I decline, the office will discuss available care/documentation alternatives consistent with applicable obligations. I may withdraw permission for future recording verbally or in writing; recording will stop after withdrawal. Withdrawal does not undo prior processing or require deletion of records that must be retained. Consent applies to future visits until withdrawn or a material change requires renewed consent.

6. ACKNOWLEDGMENT

I have read this form, received an explanation of the service and retention policy, and had questions answered. I knowingly consent to audio recording and AI-assisted processing as described.

Patient / Representative signature _____ **Date** _____

Representative printed name / relationship: _____

Staff witness: _____ Date: _____

OFFICE USE: Verify consent before recording. Obtain consent from all other participants as required; this patient's signature does not consent on their behalf.