

Last Name	First Name	Title (Mr./Mrs, etc.)

Middle Initial	Nick Name	Marital Status	Spouse Name

Home Address	City	State	Zip

Home Phone	Work Phone	Cell Phone

Date of Birth	Social Security Number	E-mail Address

Employer Name and Address

Emergency Contact	Phone Number	Relationship

Who may we thank for referring you?

Do you have dental insurance that you would like us to help you file?  Yes  No

**Consent:**

1. I authorize Dr. Kelly and his staff to take necessary x-rays, examine my head/neck region and to collect other information to make a thorough diagnosis.
2. After diagnosis, I realize that Dr. Kelly will discuss treatment options with me. I will be given an opportunity to ask questions regarding treatment. I agree that my scheduling treatment signifies my consent to that treatment.
3. I consent to the use of dental local anesthetics and understand that there are certain risks involved in their use. I may ask questions about the risks of anesthetics.
4. I agree to be responsible for payment of all services performed on me. I understand that an 18% APR late fee will be added to outstanding balances.
5. I understand that any dental insurance benefits I have represent a contract between the subscriber and the insurance company. I am responsible for payment of all services, regardless of the outcome of insurance benefits.

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

Witness: \_\_\_\_\_

Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**REGISTRATION**

Patient's Name: Last First Middle Initial

\_\_\_\_\_

When was your last dental examination?  
 \_\_\_\_\_

When was your last complete set of dental x-rays?  
 \_\_\_\_\_

Do you have any dental problems at this time? If so, describe:  
 \_\_\_\_\_

Would you like us to discuss options to improve the appearance of your teeth?  
 Yes No

Do you clench or grind your teeth?  
 Yes No

Circle all that apply:  
 Manual Toothbrush Powered Toothbrush Floss Waterpick Other

Rate your oral health:  
 Best 5 4 3 2 1 Worst

Rate the appearance of your teeth:  
 Best 5 4 3 2 1 Worst

Do you have any special needs from your dental office?  
 \_\_\_\_\_

Do you require antibiotics prior to dental visits due to an artificial joint or heart condition?  
 Yes No

Name of Physician:  
 \_\_\_\_\_

Preferred Pharmacy:  
 \_\_\_\_\_

**Do you have or have you ever had: Please circle Yes or No**

Abnormal Bleeding	Y	N	Thyroid Problems	Y	N	Cancer	Y	N
Anemia	Y	N	Kidney Problems	Y	N	Chemotherapy	Y	N
Blood Transfusion	Y	N	Liver Problems	Y	N	Radiation Treatment	Y	N
High Blood Pressure	Y	N	Hepatitis A	Y	N	Tobacco Use	Y	N
Low Blood Pressure	Y	N	Hepatitis B	Y	N	Psychiatric Treatment	Y	N
			Hepatitis C	Y	N	Other Conditions Not Listed	Y	N
			HIV+ / AIDS	Y	N	<b>Women:</b>		
			Venereal Diseases	Y	N	Pregnant?	Y	N
Heart Attack	Y	N				Nursing?	Y	N
Heart Surgery	Y	N	Epilepsy	Y	N	Birth Control?	Y	N
Heart Defect	Y	N	Seizures			<b>ALLERGIES</b>		
Abnormal Heart Rhythm	Y	N				Aspirin	Y	N
Mitral Valve Prolapse	Y	N	Diabetes	Y	N	Codeine	Y	N
Rheumatic Fever	Y	N	Osteo-Arthritis			Dental Anesthetics	Y	N
Stroke	Y	N	Rheumatoid Arthritis	Y	N	Erythromycin	Y	N
			Sinus Problems	Y	N	Latex	Y	N
			Drug Abuse	Y	N	Metals	Y	N
Asthma	Y	N	Ulcers	Y	N	Penicillin	Y	N
Difficulty Breathing	Y	N	Acid Reflux	Y	N	Tetracycline	Y	N
Emphysema	Y	N	Colitis	Y	N	Other Medications	Y	N
Tuberculosis	Y	N	Fever Blisters	Y	N			
			Glaucoma	Y	N			

Signature of Patient or Guardian (if under 18 yrs. old)  
 Doctor's Initials \_\_\_\_\_

\_\_\_\_\_ Date

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# 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 02/10/2003, 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.

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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 \$0.50 for each page, \$10.00 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.

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#### 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: Dr. Michael Kelly

Telephone: 386-775-9933

Fax: 386-775-9604

E-mail: mtkellydmd@aqd.org

Address: 1025 South Volusia Avenue, Orange City, FL 32763

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT\*

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,  
but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

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# **WELCOME**

## **CHANGING LIVES ONE SMILE AT A TIME**

Michael T. Kelly, D.M.D., P. A.

1025 South Volusia Avenue  
Orange City, FL 32763  
(386) 775-9933

Website: [www.mtkellydmd.com](http://www.mtkellydmd.com)  
E-mail: [mtkellydmd@agd.org](mailto:mtkellydmd@agd.org)

### Our Commitment to You

Our team is committed to educating patients and assisting them in attaining optimum oral health. We strive to restore function and increase confidence through beautiful smiles.

### Our History

Dr. Kelly and his wife, Jennifer (a dental hygienist), returned to the DeLand area in 1993 with a vision to build a dental office committed to personal attention and excellence. Since opening our doors in 1994, the practice has grown yet our dedication to patient service and our caring environment have not changed.

### Dr. Kelly's Background

Dr. Michael Kelly dreamed of becoming a dentist since 6<sup>th</sup> grade, after working with his orthodontist on a research project. Continuing to pursue the dream, he worked as a dental assistant through high school and college. He received his Bachelor of Science degree from Stetson University in 1989, graduating magna cum laude. In 1993, he graduated from the Medical College of Georgia with his Doctorate of Dental Medicine, and was recognized for outstanding patient care. After completing more than 600 hours of education and passing a rigorous written examination, he received his Fellowship award in the Academy of General Dentistry in 2003. He continues to remain on the cutting edge of dental education.

Dr. Kelly and his family reside in Orange City.

## Your First Visit

You will experience the difference in our office with your first contact. You will meet Dr. Kelly and the rest of the staff, and our caring team will work to understand your needs and desires as they evaluate your current level of health. You can expect to spend about an hour to an hour and a half in the office on your first visit. During that time, you will have your teeth examined and photographed. The information gathered at this visit will be used to develop a customized plan to restore you to oral health.

## Our Expectations of You

We ask our patients to make a continued effort to maintain proper oral health through proper brushing and flossing, and by keeping regular preventative visits with our office.

Because we work hard to respect your time, we expect you to do the same for us. Should it be necessary to change the time that is exclusively reserved for you, we request to be notified 2 business days in advance.

In order to maintain the high level of care we provide, we expect patients to pay for services when they are rendered.

## Dental Insurance

Dental insurance, or “dental assistance” as it should be called, has been provided by your employer to help cover some of the costs of routine dental treatment. Our office will assist you in filing insurance claims for most companies. The patient is, however, responsible for the payment of services when rendered. Remember, the best “insurance” is regular preventative visits to the dentist.

## Emergency Information

Should an emergency situation arise, Dr. Kelly may be reached as follows:

During office hours – Call the office as soon as possible and we will make arrangements to see you promptly.

After office hours – Dr. Kelly can be reached on his cell phone at (386) 804-6315.

Once again,  
**Welcome to our office!**

# DENTAL BENEFIT INFORMATION SHEET

Name of Employee/Insured: \_\_\_\_\_

Social Security Number of Insured: \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_

Coverage Type: Individual \_\_\_\_\_ Family \_\_\_\_\_

Group Number: \_\_\_\_\_

Blue Cross/Blue Shield Number (if applicable) \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Patients Covered by Plan	Date of Birth	Relationship to Insured

**I authorize the release of medical or dental information in order to properly process my insurance claim. I understand that I am ultimately responsible for payment of all services regardless of my dental benefits.**

**Signature of Insured:** \_\_\_\_\_ **Date:** \_\_\_\_\_