



CHARLES W. MOORE, D.M.D.
JULIANA Y. CHANG, D.M.D.

6025 Memorial Highway • Tampa, FL 33615 • Phone: (813) 886-2527 • Fax: (813) 887-3225

Patient Information (Please Print)

Today's Date: _____

First Name _____ MI _____ Last Name _____

Preferred Name _____

Sex: M F Marital Status: Single Married Divorced Other Date of Birth _____

Social Security # _____ Driver's License # _____

Address _____

City _____ State _____ Zip _____

Mobile (_____) _____ Home Phone (_____) _____ Work (_____) _____

Email Address _____

Person Responsible for this account _____ Relationship to Patient: Self Spouse Parent Other _____

How did you hear about our office? _____

Insurance Information

Primary Dental Insurance

Company Name _____ Phone (_____) _____

Policy Number _____ Group Number _____

Address, City, State, Zip _____

Primary Insurance Subscriber (if other than patient)

First Name _____ MI _____ Last Name _____

Social Security # _____ Driver's License # _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work (_____) _____ Mobile (_____) _____

Relationship to Patient: Spouse Parent Other _____

Secondary Dental Insurance (if applicable)

Company Name _____ Phone (_____) _____

Policy Number _____ Group Number _____

Address, City, State, Zip _____

Patient name _____

Today's Date _____

Patient Medical/Dental History

Primary Physician's Name _____ Phone number _____ Date of last visit _____

Preferred Pharmacy _____ Address (Cross-roads OK) and/or Phone number: _____

Emergency Contact _____ Relationship to patient _____ Phone number _____

Are you currently under medical treatment? Yes No If yes, please describe _____

Have you had any major surgical operations or serious illnesses? Yes No If yes, please describe _____

Please list any prescribed or over-the-counter medications, vitamins, and supplements, that you are currently taking: _____

Do you take any blood thinners like Warfarin or daily aspirin? Yes No If yes, please describe _____

Do you currently take or have you ever taken any IV or oral bisphosphonate medications (for low bone density, osteoporosis, or cancer) such as Fosamax, Boniva, Prolia, Zometa, Reclast, Actonel, etc? Yes No If yes, please describe and for how long? _____

Have you ever had any joints replaced? Yes No If yes, please describe _____

Have you ever been advised to take antibiotics prior to any dental procedures? Yes No If yes, please describe _____

Do you use tobacco products including cigarettes, cigars, smokeless/chewing tobacco, or e-cigs? Yes No
If so, please describe, and how often/much? _____

Do you use any recreational drugs? Yes No If yes, please describe _____

Do you use any controlled substances? Yes No If yes, please describe _____

(Women) Are you pregnant or think you may be pregnant? Yes No Nursing? Yes No Taking oral contraceptive? Yes No

Are you allergic to the following:	Yes	No		Yes	No		Yes	No
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin / Amoxicillin	<input type="checkbox"/>	<input type="checkbox"/>	Barbituates	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>
Other antibiotics: _____	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other pain medications	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies: _____		

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema / COPD	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis / Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Headaches, frequent	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints / Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease, clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis type ____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	High / Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head/neck	<input type="checkbox"/>	<input type="checkbox"/>
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach troubles/ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I / II	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers listed above **and** list any other medical conditions not addressed above: _____

Do any of the following apply?	Yes	No		Yes	No	
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment (present/past)	<input type="checkbox"/>	<input type="checkbox"/>	Main Dental Concern(s): _____ _____ _____ _____ _____
Sensitivity to hot/cold food or liquids	<input type="checkbox"/>	<input type="checkbox"/>	Frequent biting of lips/cheeks	<input type="checkbox"/>	<input type="checkbox"/>	
Sensitivity to sweet food or liquids	<input type="checkbox"/>	<input type="checkbox"/>	Clicking of jaw	<input type="checkbox"/>	<input type="checkbox"/>	
Sores/Lumps in or near mouth	<input type="checkbox"/>	<input type="checkbox"/>	Pain from jaw joint, ear, or side of face	<input type="checkbox"/>	<input type="checkbox"/>	
Head/neck/jaw injuries	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult tooth extraction(s) in the past	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>	
Prolonged bleeding after extraction	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Current or past dentures/partials	<input type="checkbox"/>	<input type="checkbox"/>	Clenching or grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	

Doctor Signature _____



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Financial Policy

Our experience has shown us that many questions and/or problems about our financial policies can be avoided by understanding our office policies. As a courtesy, we will be happy to file your primary insurance benefits, though we are not obligated to do so.

Our office policy requires that **PAYMENT IS DUE IN FULL** at the time your dental treatment is rendered. In addition to cash, we accept check, Visa, Mastercard, Discover, and American Express with proper identification. Should you be interested in financing, our office accepts Care Credit 6 month and 12 month interest-free financing. If you are unfamiliar with Care Credit healthcare financing, please ask for details.

Your dental insurance plan is a contract between you, your employer, and the insurance company. Our office does not determine or guideline your benefits. As a courtesy to our patients with dental insurance, our doctors may agree to accept a patient's insurance assignment. If our front desk staff is able to determine the expected coverage of your insurance plan, our office will submit your claim to your insurance company. However, it is **YOUR RESPONSIBILITY** to be familiar with **YOUR** insurance policy, including knowledge of your deductibles, yearly maximums, co-payments, frequency limitations, and non-covered services. Remaining benefits for pre-treatment estimates are generated on information obtained from your insurance company at the time of inquiry. Moore Dental Care is **NOT RESPONSIBLE** for misinformation provided by and/or obtained from your insurance company, including the amount of remaining benefits. We will wait up to 60 (sixty) days for the insurance payment to be received and applied to your account. The responsible party for the account must pay any deductible, co-payments, non-covered services, or difference between the insurance company fees and the office fees at the time services are completed. It is **YOUR RESPONSIBILITY** to notify the office staff if there are any changes in your insurance coverage.

If, for any reason, your insurance company does not pay the insurance claim or does not pay the full amount of the expected benefit within 60 (sixty) days from the date of service, the balance will be transferred from an insurance balance to a personal balance. A statement will be sent to the responsible party and payment will be expected within 10 (ten) days. Any unpaid balance will be subject to a 1.5% interest rate per month. There will be a \$25 service charge on any returned checks. If your account is turned over to a collection agency, you are responsible for any costs incurred in collection of said balance(s), which may include collection agency fees up to 35% of your outstanding balance, court costs, and attorney fees.

An important issue to remember is that the doctor will prescribe dental treatment on the basis of their patient's needs, not on the basis of what dental treatment the insurance will or will not cover.

Please sign only after you have read our policy in its entirety and are comfortable with the terms. If you would like a copy of our financial policy, please request one from the front desk after signing. Thank you.

Patient or Guardian Signature

Date



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Cancellation Policy:

Our office requires notification of at least 1 (one) business day if you need to cancel or reschedule an appointment. Tardiness in excess of 15 minutes may result in a failed appointment if the doctor or hygienist cannot accomodate you in the schedule. Failure to contact our office in advance will result in a \$50.00 per half hour fee assessed to your account. The amount of hours is determined by the length of time your appointment was booked for, based on your recommended treatment for that appointment. As a courtesy, your first missed appointment will receive a warning letter since we understand that unforeseen circumstances may arise. Thereafter, the \$50.00 per half hour fee will apply.

Patient or Guardian Signature

Date

Authorization and Release:

I certify that I have read and answered the questions on the Patient Information Form and Patient Medical & Dental History accurately to the best of my knowledge. I understand the information given to me regarding the office's Financial and Cancellation Policies. I understand that withholding or providing incorrect information can be dangerous to my health. I hereby authorize and request the performance of dental services for my child or myself.

I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child or myself during the period of such dental care, to third party payors (i.e. dental insurance companies) and/or other health practitioners (i.e. endodontists).

If applicable, I authorize and request my insurance company to pay directly to the dentist or dental group such insurance benefits otherwise payable to me. I understand that I am financially responsible for any deductible, copayments, non-covered services, differences between the insurance company fees and the office fees, or balances unpaid by my insurance company.

I understand that in the event I default on my payment for completed services, I can be charged an amount to cover collection, court, and attorney fees. Initial request of records/x-rays may be obtained with 48 hours' notice. Actual cost of reproducing written records is \$20.00 an hour for labor and overhead cost, plus postage if necessary per Florida Statute 395.3025. Copies requested for the first 25 pages, the cost shall be \$1.00 per page. For each page in excess of 25 pages, the cost shall be \$0.25 thereafter.

Patient or Guardian Signature

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Communications Consent

I consent to Moore Dental Care contacting me electronically via the cell phone and/or email address on file for the purpose of receiving appointment reminders, notifications that I need to make an appointment, dental records, reminders of uncompleted treatment, or account information. I understand that I can cancel this consent at any time.

Patient or Guardian Signature

Date

If you would NOT like to be contacted by email or text messages you may Opt Out of one or both by initialing below.

I elect to Opt Out of email

I elect to Opt Out of text messaging

If you change your mind at any time, you may notify us by calling us at (813)886-2527

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and health-care operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

Patient or Guardian Signature

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on **February 10, 2026**, and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes, and we will make the new Notice available upon request. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer – **Charles W. Moore & Office Administrator**.

Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established “minimum necessary” or “need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013, immunization records for students may be released without authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures” of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren’t capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. **Lists, if requested, we charge \$1.00 per page for the first 25 pages and \$0.25 for each page in excess of 25 pages plus postage.**

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider’s refusal of an individual’s request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Special Privacy Protections for Certain Health Information: Some health information related to **substance use disorders (SUD)** is protected by additional federal privacy laws. Although this facility does not provide substance use disorder treatment, these laws may apply if such information appears in a patient’s record.

When applicable:

- SUD information generally cannot be shared without your written permission
- It cannot be used for law enforcement, employment, housing, or benefit decisions
- Federal law prohibits discrimination based on this information

In limited situations, such as a medical emergency or when required by law, disclosure may be allowed. We are committed to protecting your privacy and safeguarding all health information. If the situation arises, we will use the substance abuse confidentiality consent form to authorize disclosure. If you have questions, please contact our Privacy Officer.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. We are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: This facility does not engage in fundraising activities. We will not use or disclose your protected health information for fundraising purposes.

Sale of PHI: We are prohibited to disclose PHI without authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. **Copies, if requested, we charge \$1.00 per page for the first 25 pages and \$0.25 for each page in excess of 25 pages plus postage. We do not charge for emailed records.** Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

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**QUESTIONS AND COMPLAINTS:** You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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. **HOW TO CONTACT US:**

Practice Name: **Moore Dental Care**

Privacy Officer: **Charles W. Moore & Office Administrator**

Address: **6025 Memorial Highway Tampa, FL 33615**

Telephone: **813-886-2527**