At this time our office is not seeing Covid-19 vaccinated patients. We apologize for any inconvenience and are waiting for official guidance from the CDC or ADA as to how to treat Covid-19 vaccinated patients safely for everyone involved.

White Sands
DENTISTRY

We are committed to providing you with the highest quality care so you may achieve optimum lifetime oral health. White Sands Dentistryhas earned the trust of both patients and their functional medicine providers. We work collaboratively with patients and their health-care team to support optimal wellness, providing material choices and dental solutions designed to meet your health goals while maintaining the highest dental standard of care. Our administrative and clinical teams ensure a seamless experience from start to finish. From the moment you step into our office, we are committed to you and your well-being, delivering the highest standards in optimal wellness and biological oral health dentistry.Thank you for choosing White Sands Dentistry and welcome to our practice.

NOTICE OF PRIVACY PRACTICES

White Sands Dentistry
520 48th. St. Ct. E. Bradenton, Fl 34208
941-748-9393 Phone
941-748-9696 Fax

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment, preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). “Health care operations” mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office, or to report a crime that happened somewhere else;

- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

- uses or disclosures for health related research;

- uses and disclosures to prevent a serious threat to health or safety;

- uses or disclosures for specialized government functions, such as for the protection of the presidentor high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

- disclosures of Treatment Not Required to insurance co. if the patient pays in cash

- disclosures of PHI not allowed for marketing purposes without further written consent

- disclosures of de-identified information;

- disclosures relating to worker's compensation programs;

- disclosures of a "limited data set" for research, public health, or health care operations;

- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

- disclosures to "business associates" who perform health care operations for us and who commit to

Respect the privacy of your health information;

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation, you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time

unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOU'RE RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment). Payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or Email shown at the beginning of this Notice

- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using Email to your personal Email address. We will accommodate these requests if they are reasonable and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or Email shown at the beginning of this Notice.

- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or Email shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or Email shown at the beginning of this Notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we

can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or Email show at the beginning of this Notice.

- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or Email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or Email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

Acknowledgment of receipt of privacy practices

You may REFUSE to sign this acknowledgment. However, without your signature, we cannot treat you today or in the future until signed below.

I, _____, have received a copy of this notice of privacy practices. I give my permission should it be necessary to share my treatment information. A Copy of this notice and acknowledgment will be kept in my patient file.

Please print your name:

X _____ **Date:** _____

Signature of patient or Guardian:

X_____**Date:** _____

Payment and Credit/Debit card on file Agreement

Our office strives to provide supportive communication in regard to all aspects of your dental care from the dental procedure to the manner in which you pay for dental services. We hope this financial policy clearly explains management of dental fees. Any questions that you have, however, are certainly welcomed and should be directed to Alicia, our Office Manager.

Forms of payment: Cash, Check, Visa, MasterCard, American Express, and Discover are accepted. There will be a 3.5% credit card processing fee assessed to all credit card transactions.

New Patient Appointments: If you are a new patient and are being seen for a specific dental emergency, we request payment in full for your first visit. You will need to establish with our practice at a later date by completing full medical history forms and a full exam with Dr. Mallery. If you are a non-emergent new patient payment is due in full at time services are rendered.

Minor Children: The adult accompanying the minor is responsible for payment of services. **Minors must always be accompanied by an adult.**

Consent:

The undersigned hereby authorizes Dr. Mallery to perform and all forms of treatment, medication and therapy that may be indicated. I also understand that use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered.

ALL PATIENTS will be asked for their credit or debit card information at time of booking an appointment. Card numbers stored will only be used for missed appointment fees and outstanding balances only. Patients will be notified of this charge before applying any applicable charges to their account.

Card type:

- ☐ VISA
- ☐ MASTERCARD
- ☐ DISCOVER
- ☐ AMERICAN EXPRESS

Card Number: _____

Exp Date: _____

CVC: _____

PATIENT SIGNATURE: _____**DATE:** _____

Cancellation or missed appointment fee Agreement

When we make your appointment, we are reserving a room for your particular needs. We ask that if you need to change an appointment, please give us at least a 48 hour notice. We use a third party company to provide you with text messages, emails and phone call notifications of your scheduled appointment times and dates. We ask that you confirm your appointment via email, text or by simply calling our office. If for some reason your appointment is not confirmed or rescheduled within 48 hours of your scheduled appointment time we will delete your appointment and there will be $100 missed appointment fee charged to your provided stored form of payment. We will notify patient of any applicable charged prior to submitting payments. Repeated cancellations or missed appointments will result in a loss of future appointment privileges.

Sincerely,

Dr. Mallery and White Sands Dentistry Staff

Patient Signature: _____ **Date**: _____

Patient Intake Form

What is your chief dental concern today?

_____

Name: _____

Address: _____

Email: _____

Phone: _____

Gender: M ____ F____ Age:____ Ethnicity:_____

DOB: _____/_____/_____ Place of birth:_____

Current Weight: _____ Weight a year ago? ____Your ideal weight:_____

Height_____ Marital status:___ # of children:_____

Pets • Yes • No

Occupation:_____

Emergency Contact

Name & Relationship: _____Phone:_____

Primary Care Doctor

Physician: _____ Phone: _____

How did you hear about our office?

- ☐ Website
- ☐ IAOMT/HDA/IABDM
- ☐ Doctor referral
- ☐ Friend/Family
- ☐ Social Media

Dental History

Date of your last dental cleaning? _____

Date of your last oral cancer screening? _____

Date of your last complete X-rays? _____

What is the name of your last Dentist? _____

Why did you leave your previous dentist? _____

Do you smoke or use chewing tobacco? _____ How often? _____ How long? _____

Any TMJ problems (Jaw joint dysfunction)?

_____

Do you have Amalgam dental fillings? _____

Have you received orthodontic treatment? _____

Have you had any dental surgeries? If so, when? _____

Do you have sleep apnea? _____

Do you wear a night guard? _____

Do you wear an orthodontic retainer? _____

Are you currently experiencing any of the following?

- ☐ Tooth ache
- ☐ Jaw joint pain
- ☐ Grinding/clenching of teeth
- ☐ Loose, tipped or shifting teeth
- ☐ Difficulty eating due to missing teeth
- ☐ Slow healing mouth sores
- ☐ Headaches, earaches or neck pain
- ☐ Fillings or teeth breaking
- ☐ Bleeding, swollen or irritated gums
- ☐ Bad breath
- ☐ Tooth abscess
- ☐ Canker sores
- ☐ Mouth breathing
- ☐ Sensitivity to cold/hot
- ☐ Sensitivity when chewing

We ask our patients for detailed medical history due to the fact that many systemic conditions and diseases are linked or directly caused by dental conditions. We thank you for your time filling out the following pages.

Insert medications you are currently taking below

Medications	Dosage/ How often	Date Started	Last Taken	Brand Name	Response/Symptoms
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Have you ever taken medications that alter bone physiology?

(Fasomax, Boniva, Actonel, Zometa etc) _____

Insert supplements you are currently taking below

List all vitamins, minerals and other nutritional supplements that you are taking. Indicate whether mg (milligrams) or IU (international unities) etc. and the form (e.g., calcium carbonate vs. calcium lactate) when possible.

Supplement	Dosage/ How often	Date Started	Last Taken	Brand Name	Response/Symptoms
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

List all allergies to medications you have below

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all vaccines you have received in your lifetime

(Examples: Flu, Hepatitis, Travel and Covid-19)

1. _____

2. _____

3. _____

4. _____

5. _____

Chief Medical Concerns: In order of importance. Please include current health concerns

Describe Problem	Mild/Moderate/Severe	Resolution Approach Current/Past	How successful? Mild/Moderate/Severe
Example: Acid reflux	Mild	Antacids	Moderate
1.			
2.			
3.			
4.			

ANY PAST ILLNESS/SURGICAL/TRAUMAS/HOSPITALIZATION HISTORY If you have experienced recurrence of an illness, please indicate when or how often under comments.

Illness	When/Onset	Comments

Nutritional History

Do you have any known food sensitivities?

• Yes • No

If yes, please list:

_____

Are you allergic to any known foods? • Yes • No

If yes, please list:

_____

Do you currently follow a special diet or nutritional program

- ☐ Vegeterian
- ☐ Vegan
- ☐ Blood type diet
- ☐ Paleo
- ☐ Mediterranean Diet
- ☐ Ketogenic
- ☐ Other _____

Patient Physical Health History

Please check all that apply

Skin

- ☐ Rash/ Hives
- ☐ Acne
- ☐ Psoriasis/ Eczema
- ☐ Dry/Oily/Normal
- ☐ Lumps
- ☐ Skin Cancer (type) _____
- ☐ Perspiration
- ☐ Warts/Moles
- ☐ Other _____

Head

- ☐ Headache
- ☐ Migraines
- ☐ Dandruff
- ☐ Head injury
- ☐ Other _____

Nose

- ☐ Frequent colds
- ☐ Sinus Congestion
- ☐ Polyps
- ☐ Nosebleeds
- ☐ Post nasal drip
- ☐ Seasonal allergies
- ☐ Other _____

Eyes

- ☐ Dry/Watery
- ☐ Blurred vision
- ☐ Double vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Sties
- ☐ Dark itchy eyelids
- ☐ Other _____

Neck

☐ Stiffness
☐ Tension
☐ Swollen glands
☐ Other _____

Respiratory

☐ Tuberculosis (TB)
☐ Sleep Apnea
☐ Bronchitis
☐ Emphysema
☐ Pneumonia
☐ Asthma
☐ Other _____

Cardiovascular

☐ Hypertension
☐ Elevated Cholesterol
☐ Murmurs
☐ Palpitations
☐ Arrhythmias
☐ Edema
☐ Anemia (type) _____
☐ Endocarditis
☐ Artificial Valve
☐ Other _____

Gastrointestinal

☐ GERD (reflux)
☐ Bloating
☐ Inflammatory Bowel Disease
☐ Gall Bladder Disease
☐ Gall stones
☐ Fatty Liver
☐ Liver Cirrhosis
☐ Hepatitis A, B or C _____
☐ Chron's Disease
☐ Ulcers
☐ Irritable Bowel Disease
☐ Celiac Disease
☐ Other _____

Urinary Tract

- ☐ Kidney Stones
- ☐ Kidney Dialysis
- ☐ Incontinence
- ☐ Frequent UTI's
- ☐ Other _____

Male Only

- ☐ Testicular pain/ Swelling
- ☐ Hernia
- ☐ Prostate Disease
- ☐ Other _____

Female only

- ☐ Heavy menstrual bleeding
- ☐ Menstrual cramping/Pain
- ☐ Number of pregnancies _____
- ☐ Take birth control
- ☐ Abnormal Pap smears
- ☐ Breast Implants how old? _____
- ☐ Last mammography _____
- ☐ Hormone replacement _____
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Other _____

Musculoskeletal

- ☐ Arthritis
- ☐ Tremors
- ☐ Leg cramps
- ☐ Pain/Weakness
- ☐ Joint replacement
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Arm or leg numbness/tingling
- ☐ Muscle pain
- ☐ Other _____

Nervous System

- ☐ Paralysis
- ☐ Tingling/Numbness
- ☐ Seizers
- ☐ Sciatica
- ☐ Carpal Tunnel
- ☐ Fainting
- ☐ Other _____

Weight

- ☐ Compulsive eating
- ☐ Water retention
- ☐ Underweight
- ☐ Binge eating
- ☐ Bulimia
- ☐ Obesity
- ☐ Other _____

Energy/Activity

- ☐ Hyperactivity
- ☐ Apathy/Lethargy
- ☐ Restlessness
- ☐ Fatigue/Sluggishness
- ☐ Other _____

Inflammatory/Autoimmune

- ☐ Multiple Sclerosis
- ☐ Lyme
- ☐ Rheumatoid Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Lupus
- ☐ Immune Deficiency Disease
- ☐ Environmental Allergies
- ☐ Multiple Chemical Sensitivities
- ☐ Food Allergies
- ☐ Other _____

Metabolic/Endocrine

☐ Hashimoto's Thyroiditis
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Grave's Disease
☐ Type 1 Diabetes
☐ Type 2 Diabetes
☐ Adrenal burnout
☐ Other _____

Client Mental Health History

☐ Depression
☐ Suicidal
☐ Anxiety
☐ Nervousness
☐ Anger/Irritability
☐ High strung/tense
☐ Fear/ Panic
☐ Mood swings
☐ ADHD/ADD
☐ Bipolar disorder
☐ Eating disorder
☐ Psychosis
☐ Schizophrenia
☐ Other _____

Cancer? Where? When? What type?
_____

Have you ever received chemotherapy? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian

X_____ **Date** _____

Signature of Doctor

X _____

Hipaa Privacy Notice

There has been a development in the health industry that requires us to get your written permission in case we ever need to share your treatment information with a healthcare specialist or medical/dental lab. When you sign this form, you give us your approval to share our treatment information with the aforementioned and you acknowledge that you are aware of your potential need to do so.

Signature of Patient, Parent or Guardian

X _____ **Date** _____