

WELCOME

Thank you for selecting our dental office. To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you.

1) PATIENT INFORMATION

This appointment is for Yourself Your Child

Patient Full Name _____ Social Security # _____

Birth Date _____ Age _____ Male Female _____

Address _____ City _____ State ____ Zip _____

Full Time Student _____ Yes No School Name _____

Employer _____ Occupation _____

Previous Dentist _____ Previous Dentist Phone _____

Current Physician _____ Current Physician Phone _____

Whom may we thank for referring you _____

2) TELEPHONE & EMAIL

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____

Home Phone _____ Work Phone _____

3) RESPONSIBLE PARTY

Who is responsible for this patient

Full Name _____ Social Security # _____

Are you Single Married Divorced Widowed

Birth Date _____ Age _____ Male Female _____

Address _____ City _____ State ____ Zip _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____

4) INSURANCE INFORMATION

Dental Coverage Yes No

Insured's Name _____ Relation _____

Insured's Social Security # _____ Birth Date _____

Insurance Group # _____ Insurance Policy # _____

Insurance Co. Name _____ Insurance Co Phone _____

Please continue on next page.

5) DENTAL HISTORY

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? Yes ___ No ___

Are you currently in pain? Yes ___ No ___

Do your gums ever bleed? Yes ___ No ___

Have you ever had difficulties associated with any previous dental work? Yes ___ No ___

Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)? Yes ___ No ___

Have your tonsils or adenoids been removed? Yes ___ No ___

Do you floss on a regular basis? Yes ___ No ___

6) MEDICAL HISTORY

Do you consider yourself in good medical health? Yes ___ No ___

Are you taking any medications? Yes ___ No ___

If so, please list here? _____

Are you allergic to any medications? Yes ___ No ___

If so, please list here? _____

(Women) Are you currently pregnant? Yes ___ No ___

If so, how many weeks? _____

(Women) Are you nursing Yes ___ No ___

(Women) Are you taking birth control Yes ___ No ___

Are you allergic to aspirin? Yes ___ No ___

Are you allergic to codine? Yes ___ No ___

Are you allergic to dental anesthetics? Yes ___ No ___

Are you allergic to erythromycin? Yes ___ No ___

Are you allergic to latex or rubber products? Yes ___ No ___

Are you allergic to metals? Yes ___ No ___

Are you allergic to penicillin? Yes ___ No ___

Are you allergic to tetracycline? Yes ___ No ___

Have you ever had any of the following medical problems?

Abnormal bleeding	Yes ___	No ___	Hepatitis	Yes ___	No ___
Alcohol / Drug abuse	Yes ___	No ___	Herpes / Fever Blisters	Yes ___	No ___
Anemia	Yes ___	No ___	High Blood Pressure	Yes ___	No ___
Arthritis	Yes ___	No ___	HIV / AIDS	Yes ___	No ___
Asthma	Yes ___	No ___	Kidney Problems	Yes ___	No ___
Cancer	Yes ___	No ___	Liver Problems	Yes ___	No ___
Diabetes	Yes ___	No ___	Low Blood Pressure	Yes ___	No ___
Difficulty Breathing	Yes ___	No ___	Pacemaker	Yes ___	No ___
Emphysema	Yes ___	No ___	Rheumatic Fever	Yes ___	No ___
Epilepsy	Yes ___	No ___	Seizures	Yes ___	No ___
Fainting Spells	Yes ___	No ___	Shingles	Yes ___	No ___
Frequent Headaches	Yes ___	No ___	Sickle Cell Disease	Yes ___	No ___
Glaucoma	Yes ___	No ___	Sinus Problems	Yes ___	No ___
Hay Fever	Yes ___	No ___	Stroke	Yes ___	No ___
Heart Attack	Yes ___	No ___	Thyroid Problems	Yes ___	No ___
Heart Murmur	Yes ___	No ___	Tuberculosis	Yes ___	No ___
Heart Surgery	Yes ___	No ___	Ulcers	Yes ___	No ___
Hemophilia	Yes ___	No ___	Venereal Disease	Yes ___	No ___

4) ACKNOWLEDGEMENT & AUTHORIZATION

I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICE

* 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

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Appearance Implants & Laser Dentistry
6390 W. Indiantown Rd. Jupiter, FL 33458
Tel: 561-741-7142 Fax: 561-741-7914

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 January 1, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care 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 effect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we can not 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 Patients 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 you with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your 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 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 health care. 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 to the health and 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 inmates or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, e-mail, 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 can not 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. You may also request access by sending us a letter to the address at the end of this Notice. 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, health care 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 explanations 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 notification 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 may also 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 us for our Privacy Contact Officer