VIP | VERO IMPLANTS & PERIODONTICS

NAME _____

LOCAL ADDRESS _____
Number *Street* *City* *State* *Zip Code*

BILLING ADDRESS _____
(If different than above) *Number* *Street* *City* *State* *Zip Code*

DATE OF BIRTH _____ SS# _____ EMAIL ADDRESS _____

HOME PHONE _____ MOBILE PHONE _____

MARITAL STATUS _____ SPOUSE (OR S.O) _____ PHONE _____

DO YOU HAVE DENTAL INSURANCE Y / N INSURANCE COMPANY _____
Please present card to receptionist

POLICY HOLDER _____ DATE OF BIRTH _____ SS# _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

MEDICAL HISTORY

Primary physician _____ Specialty _____

Additional physician _____ Specialty _____

Have you ever been hospitalized or had a major surgery? Why? _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y / N

Please list **all** medications _____

_____

Please circle all that apply (past and present)

AIDS/HIV Positive	Diabetes Type I or Type II	Hepatitis B or C	Rheumatic Fever
Alzheimer's Disease	Drug Addiction	Herpes	Rheumatism
Anaphylaxis	Easily Winded	High Blood Pressure	Scarlet Fever
Anemia	Emphysema	High Cholesterol	Shingles
Angina	Epilepsy / Seizures	Hives or Rash	Sickle Cell Disease
Arthritis / Gout	Excessive Bleeding	Hypoglycemia	Sinus Trouble
Artificial Heart Valve	Excessive Thirst	Irregular Heartbeat	Spina Bifida
Artificial Joint	Fainting Spells / Dizziness	Kidney Problems	Stomach/Intestinal Issues
Asthma	Frequent Cough	Leukemia	Stroke
Blood Disease	Frequent Diarrhea	Liver Disease	Swelling of Limbs
Blood Transfusion	Frequent Headaches	Low Blood Pressure	Thyroid Disease
Breathing Problems	Genital Herpes	Lung Disease	Tonsillitis
Bruise Easily	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Cancer	Hay Fever	Osteoporosis	Ulcers
Chemotherapy	Heart Attack/Failure	Pain in Jaw Joints	Venereal Disease
Chest Pains	Heart Murmur	Parathyroid Disease	Yellow Jaundice
Cold Sores / Fever Blisters	Heart Pacemaker	Psychiatric Care	*Any serious illness not listed:*
Congenital Heart Disorder	Heart Trouble/Disease	Radiation Treatments	_____
Convulsions	Hemophilia	Recent Weight Loss	_____
Cortisone Medicine	Hepatitis A	Renal Dialysis	_____

WOMEN: Are You.....

PREGNANT? Y / N NURSING? Y / N TAKING ORAL CONTRACEPTIVES? Y / N

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

___Aspirin ___Penicillin / Amoxicillin ___Codeine ___Acrylic

___Metal ___Latex ___Sulfa Drugs ___Local Anesthetics

Do you use controlled substances or have a history of drug abuse? Y / N _____

Other?_____

PERSONAL DENTAL HISTORY

Do you have?

Discomfort at Present?	Y / N	Bleeding Gums when brushing/flossing?	Y / N
Unpleasant taste or odor?	Y / N	Any loose teeth?	Y / N
Sensitive to hot, cold or sweets?	Y / N	Pain with chewing?	Y / N
Spaces developing between teeth?	Y / N	Clicking/popping in jaw joint?	Y / N
Dentures?	Y / N	History of clenching/grinding your teeth?	Y / N

Are you interested in teeth whitening (in office or take home)? Y / N

Have you considered replacing missing teeth with dental implants? Y / N

Have you considered securing your denture/s with dental implants? Y / N

Are you pleased with the appearance of your teeth? Y / N

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 health. It is my responsibility to inform the dental office of any changes in medical status.

I consent to treatment as necessary or desirable to the care of the patient first named above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, xray, or other services that may be used by the attending doctor, or his assistant or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the financial department.

Signature of Patient, Parent or Guardian:

X_____Date:_____

Vero Implants & Periodontics, LLC
Dr. Jeffrey Brown, DMD,MS
3730 7th Terrace, Suite 301 Vero Beach, Fl 32960
(772)569-9700

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Vero Implants and Periodontics LLC, (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning _____ in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

___ HIV records (including HIV test results) and sexually transmissible diseases

___ Alcohol and substance abuse diagnosis and treatment records

___ Psychotherapy records

COMPLETE AS APPLICABLE:

1. Please send a copy of my records (including information from other health-care providers that it may contain) to _____ at _____. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.

2. Please allow _____ to pick up a copy of my records (including information from other healthcare providers that it may contain). The copies will be ready on_____.

3. I acknowledge I will be charged copying costs in the amount of _____.

By Patient: _____ Date:_____
(Print name and sign)

Or

By Patient's Representative_____ Date:_____
(Print name, sign, and describe authority)

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Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

Signature:_____

Date:_____

If you are the legal representative of the patient, please print the patients' name(s) and describe your

authority: _____

For Office Use Only

_____

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

This copy is for your records only. If requested, a copy can be given to you at the time of you appointment.

Vero Implants & Periodontics, LLC
Dr. Jeffrey Brown, DMD, MS
3730 7th Terrace, Suite 301, Vero Beach, FL 32960
(772)569-9700

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect.
This Notice takes effect 07/07/2015, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for

your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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 request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

The U.S Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C 20201
(877) 696-6755 (toll free)

Or, submit a written complaint form to us at the following address:

Dr. Jeffrey Brown, DMD,MS, Privacy Officer
3730 7th Terrace, Suite 301, Vero Beach, FL 32960
(772)569-9700; fax (772)569-9704