An Affiliated Practice Providing
AFFORDABLE DENTURES
a good reason to smile

Patient History Information

Patient ID #
For office use:

Name:____
(first name) (middle name) (last name)

Sex: _____M_____F Date of Birth: _____/_____/_____ Social Security Number: ______ - ____ - ______

Street Address:____

City:______________________ State:______________________ Zip:__________

E-Mail: ______________________ Home Phone:______________ Work Phone:______________

Cell:______________ Emergency Contact Name & Phone:______________________________

Race: ___African American ___Asian American ___Caucasian/White ___Hispanic ___Other

Name of Family Physician: ______________________ City:______________ State:______

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- What is your reason for today's visit?____
- Have you received treatment in our office previously? YES NO If so, when?______________
- How did you first learn about our affiliated dental practice providing Affordable Dentures? (circle one)

1. Magazine 2. Newspaper 3. Radio 4. Billboards/Sign 5. Brochure/Mail
6. Television 7. Yellow Pages 8. Friend/Relative 9. Internet/Web Site 10. Other Doctor
11. Outside Agency

- Did you call our toll-free information service (1-800-DENTURE) YES NO
- May we provide your name to denture product companies who may wish to send you information on their products? YES NO
- May we contact you with information about special offers and new services we may offer at Affordable Dentures? YES NO If answer is YES, what is the best way to contact you?

(Please circle all methods of communication that you prefer below.)

Mail **Phone** **Email**

Do you have commercial dental insurance? YES NO Name of Insurance:______________________
If yes, we will provide you with a special statement of services for use when you submit your claim.

YES NO Are you currently wearing dentures? If yes, when did you receive your last dentures?________

YES NO Do you use denture adhesives, paste or powder? If so, please describe________

HAVE YOU EVER HAD...

YES NO Teeth extracted? If so, when:________

Any problems? ________

YES NO Bleeding problems?

YES NO Bad reaction to anesthesia (Novocaine?)

YES NO Allergic reaction to medications? (Penicillin or Codeine)

Please circle and/or specify:________

YES NO Allergic reaction to latex? Please specify: ________

YES NO A heart attack or heart problems?

Please specify: ________ If so, when:________

YES NO Prosthetic (false) joints, knee, hip, or valves?

Please specify. ________

YES NO Circulatory problems?

YES NO Tuberculosis or other chronic ailments? For example Chronic Obstructive Pulmonary Disease or C.O.P.D.

Please specify: ________

YES NO Hepatitis or liver disease?

YES NO Diabetes or kidney failure?

YES NO Rheumatic fever or heart murmur?

YES NO A stroke? If so, when:________

YES NO High or low blood pressure? Please circle and/or specify: ________

YES NO Cancer? Where? ________ Radiation?________ Chemotherapy?________

YES NO Immune system disorder or infection including HIV?

YES NO Fainting spells or seizures?

YES NO Do you take ASPIRIN daily?

YES NO Are you taking birth control pills or using other hormonal birth control method (For example, Norplant)? Please specify:________

YES NO Are you taking, or have you ever taken prescription medication for osteoporosis (bone loss)? (For example, FOSAMAX)? Please specify:________

YES NO Are you pregnant or nursing?

YES NO Do you smoke or use tobacco products?

YES NO Do you use illegal drugs (For example marijuana or cocaine)?

YES NO Do you have any sores in your mouth?

Please list any medicines you currently take (including Herbal Supplements): ________

Other Comments: ________

To the best of my knowledge the above questions have been answered accurately. [illegible] extractions, and other services must be paid on the first visit [illegible]

PATIENT SIGNATURE:________ Date: ________

OUR PAYMENT POLICY

We gladly accept payment by cash, MasterCard, Visa and Discover.
Some offices are able to accept checks with identification.
You will need to check with the office you are visiting to confirm their payment policies.

NEW DENTURE WEARER CHECKLIST

Please Initial at <u>Each</u> Line

Order of things:

1. X-ray, estimates, impressions
2. Patient will have to wait approximately 45 min to an hour for impressions to be poured up.
3. Patient will return the same afternoon (if we have room for surgery) for extractions. It will take approximately 1-2 hours for surgery and the delivery of dentures.
4. Patient will return the following week for a Post Op check.

_____The dentures WILL feel big, bulky and loose. They are hollowed out to allow for swelling.
_____Eating will be difficult and you have to equal out the pressure by putting food on BOTH sides and mashing it together.
_____Speech will be affected.
_____There may be bulk under the top and/or bottom lip. That will go away in time, but you should expect it.
_____You need to keep them clean. It is important for healing.
_____No two patients' experiences are the same. Everyone has their own healing time and pain tolerance.
_____No two peoples' mouths are the same. No two dentures are the same.
_____We DO NOT give back teeth under ANY CIRCUMSTANCES; Florida Health and Safety Code.
_____You need to have realistic expectations. Don't get discouraged.
_____You are having extractions done and there is a good amount of "guesstimating" in the arrangement and the positioning in the teeth of an immediate denture. Adjustments will be necessary.
_____You will need time to adjust to the dentures. You will not feel 100% the same day or the next week/month.
_____Right away, they will not look and feel like natural teeth, nor function like natural teeth. They are acrylic.
_____The denture has to go back to the soft palate to form the suction.
_____In order for us to get everyone back in a timely manner, we do adjustments from 12:30-2:30 Monday thru Friday.
_____There is a difference in extraction soreness and denture soreness.
_____You may not be able to eat solid foods for 4-6 weeks
_____We do not try to make the denture fit the tissue that isn't surgically manipulated. The denture is hollowed out to allow room for soft liners and swelling.
_____ The mouth likes to exaggerate things. Some things may feel huge, but tends to be very small in the mouth
_____ You need to have soft relines done in order for the dentures to fit properly.
_____ You must keep the dentures in your mouth the 1st night. You will take them out the following day to rinse your mouth and clean.
_____You may need to use powder, Sea-Bond, or strips for adhesive for the first 2 weeks after extractions.

_____This is a team effort. We are partners in this journey. We will do absolutely everything we can to help and guide you along the way, but you as a patient must also share in the responsibility of following our directions, (Refraining from smoking; Refraining from eating hard, sticky, & sugary foods; Cleaning the dentures at least twice daily; Taking your prescribed medications; and returning for your scheduled appointments.

SIGNATURE:________________________ DATE:____________

Financial Agreement and Attendance Policy

I, the undersigned hereby agree to pay AFFORDABLE DENTURES, PORT ST. LUCIE fees for services rendered. I further agree that payment is due when which such services are rendered unless prior arrangements are made. I understand that unpaid accounts will be considered delinquent after thirty (30) days and in default after forty-five (45) days, after which time interest will accrue at 1.5% per month on unpaid balances (annual percentage rate of 18% of the legal interest rate, whichever is lower). In the event of a legal suit or collections are necessary to retrieve payment of this account, I agree to pay such attorney fees, court costs, and/or collection fees as are deemed reasonable. I waive venue jurisdiction and submit myself to jurisdiction and venue of the Courts of St. Lucie County, State of Florida. I understand that if a refund is warranted, partial refunds are issued if the prosthesis is returned after being delivered, damaged, or altered.

I agree to keep my scheduled appointments. I agree that unless my scheduled appointment is **cancelled at least 48 hours in advance**, I will be liable to pay a **broken appointment fee of $50.** Furthermore, we reserve the right not to re-schedule appointments for those that have 2 failed appointments or last minute cancellations.

I agree to arrive 10 minutes before the appointment time to allow for processing, I am also aware that if I arrive 10 minutes after the scheduled appointment time, I will be considered to be late and that I might not be able to be seen. The office will try to move the appointment to a later time that is available, but it is not guarantee, in some cases depending on the type of appointment and the availability of the schedule, we may have to reschedule to another day.

Affordable Dentures Port St. Lucie strives to provide each patient with the highest quality of care while accommodating your schedule. We reserve time allotments for each patient; therefore, keeping your appointments on a consistent basis is a key factor for establishing your dental home.

______________________	______________________	__________
Parent or Guardian	Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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

____

Please print your name here

____

Signature *Date*

We cannot discuss your protected health information (PHI) with anyone other than you[illegible] authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Relationship____________________ Name ______________________________

Relationship____________________ Name ______________________________

Relationship____________________ Name ______________________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

____

____

Employee signature Date

Notice of Privacy Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE BECAME EFFECTIVE SEPTEMBER 23, 2013.

Our commitment to your privacy
We understand that information about you and your health is very personal, and we are committed to protecting the privacy of this information. Each time you visit an affiliated dental practice providing Affordable Dentures®, we create a record of the care and services you receive. This record is necessary to provide you with high quality care and ensure we are in compliance with certain legal requirements.

This Notice will describe the ways in which we may use and disclose your medical information. This Notice applies to your personal medical information, consisting of any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

We reserve the right to change the terms of this Notice at any time. Any revision to this Notice will be applicable to all medical information we already have about you, as well as any of your medical information that we may receive, create, or maintain in the future. We will post a copy of our current Notice in a prominent location at our dental office. A copy of the current Notice in effect will be available at the Front Desk area of our dental office and on our website.

How we may use and disclose health information about you
We may use your health information, or disclose it to others, for a number of different reasons. This Notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed here.

1. Treatment. We will use your health information to provide you with medical care and services. This means that our employees, staff, and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to make decisions about your care. For instance, a dentist may read your dental chart in order to care for you properly. We will also disclose your information to others who need it in order to provide you with medical treatment or services. For instance, we may send your doctor the results of an x-ray we perform.

2. Payment. We will use your health information, and disclose it to others, as necessary to obtain payment for the services we provide to you. For instance, an employee in our business office may use your health information to prepare a bill. And we may send that bill, and any health information it contains, to your insurance company. We may also disclose some of your health information to companies with whom we contract for payment-related services.

3. Health Care Operations. We may use your health information for activities that are necessary to operate this dental practice. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other patients to plan what services we need to provide, expand, or reduce. We may disclose your health information as necessary to others who we contract with to provide administrative services. This includes our lawyers, auditors, management services providers, and consultants, for instance.

4. Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by Medicaid. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

5. Public Health Activities. We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

6. To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect, or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

7. Law Enforcement. We may disclose your health information for law enforcement purposes if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believed may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime. We must also disclose your health information to a governmental agency investigating our compliance with privacy regulations.

8. Specialized Purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We may also disclose the health information to the appropriate foreign military authority if you are a member of a foreign military. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, counter-intelligence and protection of the President, other authorized persons or foreign heads of state or to conduct special investigations. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your health information to your employer for purposes of workers' compensation and work site safety laws (OSHA, for instance).

9. To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. Family and Friends / Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a mem-ber of your family, a relative, a close friend or any other person you identify, your health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

11. Research. We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

12. Information to Patients. We may use your health information to provide you with additional information. This may include sending appointment reminders to your address. This may also include giving you information about treatment options or other health-related services that we provide.

13. Business Associates. We may share your health information with another company that performs business services for us such as management companies. If so, we will have a written contract to ensure that this company also protects the privacy of your health information.

14. Emergencies. We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your written authorization. If this happens, we will try to obtain your written authorization as soon as we reasonably can after we treat you.

15. Lawsuits and Disputes. We may disclose your health information if required by law or an order of a court that is handling a lawsuit or other dispute.

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

17. Data Breach Notification Purposes. We may use or disclose your personal health information to provide legally required notices of unauthorized access to or disclosure of your personal health information.

18. Disaster Relief. We may disclose your health information to disaster relief organizations that seek your health information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

19. Uses and Disclosures if You are Deceased. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, who were involved in your care of payment for health care prior to your death, your health information that is relevant to that person's involvement.

Your Written Authorization is Required for Other Uses and Disclosures.
The following uses and disclosures of your health information will be made only with your written authorization:

1. Uses and disclosures of your health information for marketing purposes; and,

2. Disclosures that constitute a sale of your health information.

Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to the Privacy Office noted below or our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But, the disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Health Information Rights.
Although your dental record is the physical property of our dental practice, the information belongs to you. You have certain rights with respect to your information as described below. If you wish to exercise your rights, you may write directly to the Privacy Office at the address stated at the end of this Notice.

1. Right to request a restriction on certain uses and disclosures of your information. You have the right to request a restriction or limitation on the medical information we use and/or disclose about you for treatment, payment, or healthcare operations. Additionally, you have the right to request that we limit the information we disclose about you to someone who is involved in your care or the payment for your care. For instance, you can request that we refrain from disclosing information about a procedure that you had or a treatment you were given.

   We are not required to agree to your request. However, if we do agree, we will comply with your request so long as the information is not necessary to provide you emergency care.

   Your request must be in writing, delivered to the address provided above, and must include a description of the information you wish to limit, whether you want to limit the use, disclosure, or both, and to whom you want the limitations to apply.

2. Right to inspect and/or request a copy of your dental record. You have the right to inspect and/or receive copy any medical information maintained about you that may be used to make decisions about your care. Typically, this will include your dental and billing records.

   In order to inspect and/or receive a copy of your medical information, you must submit your request, in writing to our dental practice in care of the Privacy Office at the address noted below. We may charge a reasonable fee for this service based on our cost of complying.

   In very limited circumstances, we may deny your request to inspect and/or receive a copy of your dental information. However, if your request is denied, in some cases you may request that the denial be reviewed. Such reviews are performed by an independent licensed healthcare professional chosen by the owner of our dental practice. We will comply with the outcome of the review.

3. Right to an Electronic Copy of Electronic Medical Records. If your health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your health information in the form or format you request, if it is readily producible in such form or format. If the health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

4. Right to request an amendment to your dental record. If you believe the information we maintain about you is incorrect or incomplete, you may request that we amend the information. In order to request an amendment, you must submit a written request, as described above, indicating the specific information you wish to be amended and providing the reason supporting the request. Failure to put your request in writing or provide supporting reasoning is likely to result in a denial of your request. We may also deny your request if you ask us to amend information that:

   Is accurate and complete.
   Is not part of the information which you would be permitted to inspect or receive a copy.
   Is not part of the medical information maintained by our dental practice.
   Was not created by us, unless the individual or organization that created the information is no longer available to make the amendment.

5. Right to request alternative communications. You have the right to request that we communicate with you about medical matters in a certain manner or at a certain location. For example, you may request that we limit our communications with you to contact at work or at home. Your request must be in writing, as described above, and must specify the manner in which or the location at which you wish to be contacted. All reasonable requests will be accommodated.

6. Right to receive an accounting or a list of prior disclosures of your personal health information. You have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to April 14, 2003. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to directly to the Privacy Office at the address stated at the end of this Notice.

7. Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured health information.

8. Out of Pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

9. Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website, www.AffordableDentures.com. To obtain a paper copy of this notice, please write to the Privacy Office at the address listed at the end of this Notice. Copies of the current Notice in effect will also be available at the Front Desk area.

Questions and Complaints

If you want more information about our privacy policies or have questions or concerns, please speak with the Practice Owner at the dental practice or call or write to the Privacy Office noted at the end of this Notice.

Changes to this Notice. We reserve the right to change this Notice and make the new Notice apply to health information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

If you are concerned that we may have violated any of your rights, or you disagree with a decision we made about access to your dental information or in response to a request you made in accordance with your rights and the above instructions, you may complain to us in writing delivered to:

Privacy Office
Affordable Dentures
1400 Industrial Drive
Kinston, NC 28504

Telephone: 1-800-DENTURE (1-800-336-8873)

You may also file a complaint directly with the Secretary of the U. S. Department of Health and Human Services at the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201. We will not retaliate in any way if you choose to file a complaint with us or the Secretary.

If you would like a copy of this Notice for your personal records, please ask for a copy at the Front Desk. We will also have copies generally available in the Front Desk area of our dental practice.