Vero Implant and Esthetic Dentistry

Date:	Patient Information		
Patient's Last Name: First: Middle:	SS#	Date Of Birth:	Age:
Home Address: City: State: Zip:	Home Phone:	Cell Phone: (optional)	Marital Status: (circle one) S / M / D / W
Mailing Address: City: State: Zip: (If different)	Email Address:	Occupation:	
Primary Dental Insurance:	Address	Business Phone:	

Doctor Information	
Primary Care Physician's Name:	Primary Care Physician's Phone Number:
Specialty Care Physician's Name: (If you have one)	Specialty Care Physician's Phone Number:
Second Dentist's Name: (If you have one)	Second Dentist's Phone Number:
Emergency Contact's Name:	Emergency Contact's Phone Number:

Medical History

What is your impression of your current health?

When was your last dental visit?

When was your last physical?

Please List any allergies here.

Please circle any of the following that apply to you.

Heart Attack	Asthma	Sickle Cell Disease	AIDS	Drug Addiction
Angina/Chest Pain	Emphysema	Diabetes	Stroke	Osteoporosis
High/Low Blood Pressure	COPD	Thyroid Disease	Epilepsy/Seizures	Joint Replacement
Coronary Artery Disease	Obstructive Sleep Apnea	Other Endocrine Disease	Fainting/Dizziness	Glaucoma
High Cholesterol	Other Lung Problem	Kidney Disease	Multiple Sclerosis	Acid Reflux
Heart Murmur	Bleeding Problems	Liver Disease/Jaundice	Parkinson's Disease	Cancer
Valve Replacement	Bruise Easily	Hepatitis	Psychiatric Treatment	Radiation Therapy
Stent/Bypass Graft	Anemia	HIV Positive	Depression Anxiety	Chemotherapy

* **PreMed-Antibiotic** _____

. **Women –Are you taking contraceptives or other hormones?** _____

Are you pregnant? If so, expected delivery date: _____**Are You nursing?** _____

Have you reached menopause? If so, do you have symptoms? _____

***Please list any disease of condition that is not listed**. _____

_____

***Are you or have you ever taken Bisphosphonates? List** _____

***Please list any medications that you are currently taking including supplements.**_____

Dental History	
Have you ever experienced any complication or illness following dental treatment? If so, please explain.	YES / NO
Do you smoke or use smokeless tobacco? If so, please give frequency.	YES / NO
Are you satisfied with your teeth's appearance? If not, what would you like to change?	YES / NO
Would you like information about whitening your teeth?	YES / NO
Are you fearful or anxious when visiting the dentist?	YES / NO
Would you like information about conscious sedation for your dental procedures?	YES / NO
Whom may we thank for referring you to our office?	
The above information is true and accurate to the best of my knowledge. Signature of Patient:	Blood Pressure:
Signature of Dentist:	Date:

Updates	
Please list any changes or updates to the medical history below	Date:
	Blood Pressure:
	Signature of Dentist:
Please list any changes or updates to the medical history below	Date:
	Blood Pressure:
	Signature of Dentist:
Please list any changes or updates to the medical history below	Date:
	Blood Pressure:
	Signature of Dentist:
Please list any changes or updates to the medical history below	Date:
	Blood Pressure:
	Signature of Dentist:
Please list any changes or updates to the medical history below	Date:
	Blood Pressure:
	Signature of Dentist:

5070 Highway A1A Suite E
Vero Beach FL, 32963
Phone: (772)234-5353 Fax: (772) 234-7266
Info@veroimplantdentistry.com

Dear Patient:
Please rate our performance by checking the response that best describes your evaluation. Feel free to add comments. Upon completion, please return to us. Thank you for your input and feedback.

REGISTRATION	**Excellent**	**Good**	**Poor**	**Very Poor**
1. Professional and courteous service of office staff	____	____	____	____
2. Speed and efficiency of appointment	____	____	____	____
3. Satisfactory answers to financial and insurance questions	____	____	____	____
PROFESSIONAL SERVICES				
4. Professional and courteous service of assistant's	____	____	____	____
Professional and courtesy service of hygienist's	____	____	____	____
Professional and courtesy service of dentist	____	____	____	____
5. Assistant's introducing themselves and keeping you informed	____	____	____	____
6. Hygienist explaining procedures	____	____	____	____
Dentist explaining procedures	____	____	____	____
7. Written instructions for your home care	____	____	____	____
OVERALL				
8. Cleanliness and comfort of the dental office	____	____	____	____
9. Likelihood that you would return or recommend the dental office to others	____	____	____	____
10. **OVERALL**, rating of the dental practice	____	____	____	____

Additional comments or suggestions as to how we can improve our dental office:

_____

_____

Or visit our website at www.veroimplantdentistry.com and Face Book to leave additional comments

Dentist Name: Dr. Adam Jones _____ Dr. Giuliana Diaz Jones _____

OPTIONAL INFORMATION:

NAME: _____ PHONE NUMBER:_____

DATE OF APPOINTMENT: _____

VERO IMPLANT AND ESTHETIC DENTISTRY

CONSENT FOR USE, DISCLOSURE OF HEALTH INFORMATION, AND FINANCIAL POLICY

PATIENT NAME _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. The undersigned hereby authorizes all Doctor Jones to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor Jones to make a thorough diagnosis of the patient's dental needs. I also authorized Doctor Jones to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my treatment and further authorize and consent that Doctor Jones choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dr. Adam Jones
Dr. Guiliana Diaz Jones
5070 N A1A, Suite E, Vero Beach, FL 32963
772-234-5353 Fax: 772-234-7266

Right to Revoke: You will have the right to revoke this Consent at any time by completing and submitting a Revocation of Consent form to the Contact Person as noted above.
Financial Policy: I understand that responsibility for payment for Dental Services provided in this office for my dependents or myself is mine and is due and payable at the time services are rendered. We accept cash, check, and all major credit cards.
We do not accept insurance assignment for patients with dental insurance. If you have dental insurance, we will print a claim form for you and mail it to your insurance company for reimbursement to be sent directly to you.

We have the ability to print you an estimated treatment plan once the exam, radiographs, and diagnostic models have been completed. This will allow you to know in advance the approximate number of appointment needed to complete the treatment recommended and allow you to schedule according to your financial resources. On large treatment cases we have several payment options including financing with Care Credit which are illustrated in our Financial Options Form. These options can be explained to you at any time per your request.

ALL ACCOUNTS OVERDUE IN 90 DAYS MAY BE TURNED OVER TO OUR COLLECTION AGENCY. If you have any questions concerning our financial policies, please do not hesitate to ask our staff.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT Original to be placed in your patient chart

Signature

I, _____ have had a full opportunity to read and consider the contents of this Consent for and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment, and health care operations. I authorize the release of all medical and dental information when necessary to process my insurance claims. I also understand that you may decline to treat me if I refuse this Consent.

Signature _____ Date _____

HIPAA Short Form

Notice of Privacy Practices Short Form

Our Practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rules, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our new Notice of Privacy. Our practice is complying with HIPAA'S regulations.

What is HIPAA and how does the privacy rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, and providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Policy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is the identifiable health information (IIHI)?

Any health information you provide, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment, and/or that identifies you as an individual. What is the Notice of Privacy Practice? Our practice has an official Notice of Privacy Practice posted in our treatment areas informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our treatment areas and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI.

. Treatment

. Appointment Reminders

. Release of Information to family/friends

. Payment

. Treatment Options

. Disclosures Required by Law

. Healthcare Operations

. Health related benefits & services

The following categories describe unique situations in which we may use or disclose your identifiable health information:

. Public risks

. Health oversight activities

. Lawsuits

. Law Enforcement

. Deceased patient's organ tissue donation

. Serious health threats/safety

. Research

What are your rights concerning your individually Identifiable Health Information (IIHI)?

You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below:

1. Confidential communication

2. Requesting restrictions

3. Inspections and copies

4. Amendment

5. Accounting of Disclosures

6. Right to paper copy of this notice

7. Right to file a complaint

8. Right to provide and authorization for other uses.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Dr. Adam Jones DMDMS

Dr. Guiliana Diaz Jones DDS

Vero Implant and Esthetic Dentistry

5070 Highway A1A Suite E

Vero Beach, FL 32963

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