PARAMOUNT Smile IMPLANTS
Periodontics and Implant Dentistry
"Smile with Significance"

PATIENT INFORMATION FORM

NAME _____ BIRTH DATE _____ MARITAL STATUS _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ CELLPHONE _____

OCCUPATION _____ SOC. SEC. NO. _____

NAME OF SPOUSE _____OCCUPATION _____

EMAIL ADDRESS _____ BUSINESS PH _____

NAME OF DENTIST _____PH:_____ HOW LONG _____

NAME OF PHYSICIAN _____PH:_____HOW LONG _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE _____

REASON FOR YOUR VISIT _____

INS. CO. _____ POLICY # _____ SUBCRIBER _____

MEDICAL HISTORY

DO YOU HAVE TO PRE-MEDICATE? IF YES, WHAT MEDICATION? _____ ☐YES ☐NO

DATE OF PHYSICAL EXAMINATION? _____ ARE YOU BEING TREATED BY A PHYSICIAN NOW?..... ☐YES ☐NO

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (INCLUDING ASPIRIN)..... ☐YES ☐NO

IF YES, WHAT? _____

HAVE YOU HAD SURGERY IN THE LAST 5 YEARS? (IF YES, PLEASE STATE) _____ ☐YES ☐NO

ARE YOU PREGNANT? ..... ☐YES ☐NO

HAVE YOU HAD PERIODONTAL/ORTHODONTICS TREATMENT? ..... ☐YES ☐NO

DO YOU TAKE MEDICATION FOR OSTEOPOROSIS? (FOSAMAX, BONIVA) IF SO, WE WILL PROVIDE YOU WITH MORE INFO ☐YES ☐NO

DO YOU GRIND OR CLENCH YOUR TEETH? ..... ☐YES ☐NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING MEDICATIONS OR HAVE ANY MEDICAL CONDITIONS:

	YES	NO
LOCAL ANESTHETIC ALLERGY	☐	☐
PENECILLIN ALLERGY	☐	☐
LATEX ALLERGY	☐	☐
ASPIRIN ALLERGY	☐	☐

	YES	NO
AIDS	☐	☐
ARTHRITIS	☐	☐
ARTIFICAL JOINTS	☐	☐
ARTIFICIAL HEART VALVES	☐	☐
ASTHMA	☐	☐
BACK PROBLEMS	☐	☐
BLEEDING GUMS	☐	☐
BLOOD DISEASE	☐	☐
CANCER (IF YES, LIST BELOW)	☐	☐
CHEMICAL DEPENDENCY	☐	☐
CHEMOTHERAPY	☐	☐
GASTRO PROBLEMS	☐	☐
HEART DISEASE/PROBLEMS	☐	☐
HIGH BLOOD PRESSURE	☐	☐
RHEUMATIC FEVER	☐	☐
STROKE	☐	☐

	YES	NO
ANEMIA	☐	☐
CIRCULATORY PROBLEMS	☐	☐
CORTISONE TREATMENTS	☐	☐
COUGH, PERSISTENT	☐	☐
DIABETES	☐	☐
EPILEPSY	☐	☐
FAINTING	☐	☐
GLAUCOMA	☐	☐
HEADACHES	☐	☐
HEART MURMUR	☐	☐
HEART PROBLEMS	☐	☐
KIDNEY DISORDER	☐	☐
LIVER DISORDER	☐	☐
RESPIRATORY DISORDER	☐	☐
TUBERCULOSIS	☐	☐
VENERERAL DISEASE	☐	☐

	YES	NO
HEMOPHILIA	☐	☐
HIV POSITIVE	☐	☐
LIVER DISEASE	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
NERVOUS PROBLEMS	☐	☐
PACEMAKERS	☐	☐
PSYCHIATRIC CARE	☐	☐
RADIATION TREATMENT	☐	☐
RESPIRATORY DISEASE	☐	☐
RHEUMATIC FEVER	☐	☐
SHORTNESS OF BREATH	☐	☐
SKIN RASH	☐	☐
STROKE	☐	☐
SWELLING OF FEET / ANKLES	☐	☐
TOBACCO HABIT	☐	☐
ULCER	☐	☐

OTHER ALLERGIES OR MEDICAL CONDITIONS NOT LISTED

_____

_____

GENERAL CONSENT FORM

X-RAYS: I UNDERSTAND THAT I WILL BE HAVING RADIOGRAPHIC DIGITAL X-RAYS TAKEN AND I GIVE THE CONSENT TO TAKE THEM (INITIALS: _____)

DRUGS & MEDICATION: I UNDERSTAND THAT I WILL BE HAVING ANTIBIOTICS/ANALGESICS AND/OR OTHER MEDICATIONS WHICH CAN CAUSE ALLERGIC REACTIONS LIKE REDNESS, SWELLING OF TISSUE, PAIN & ITICHING, VOMITING, AND/OR ANAPHYLACTIC SHOCK. (INITIALS: _____)

CHANGES IN TREATMENT PLAN: I UNDERSTAND THAT DURING TREATMENT IT MAY BE NECESSARY TO CHANGE OR ADD PROCEDURES BECAUSE OF CONDITIONS FOUND WHILE WORKING ON TEETH NOT DISCOVERED DURING THE EXAMINATION. I GIVE PERMISSION TO MY DENTIST TO MAKE ANY/ALL CHANGES AND ADDITIONS NECESSARY. (INITIALS: _____)

FILLINGS: I UNDERSTAND THAT EXTRA CARE MUST BE TAKEN WHEN CHEWING ON FILLINGS DONE WITHIN THE FIRST 24 HOURS TO AVOID BREAKAGE. I UNDERSTAND THAT SIGNIFICANT SENSITIVITY IS A COMMON AFTER EFFECT OF A NEWLY PLACED FILLING OR REPLACED FILLING. (INITIALS: _____)

I UNDERSTAND THAT DENTISTRY IS NOT AN EXACT SCIENCE AND THAT THEREFORE, REPUTABLE PRACTITIONERS CANNOT PROPERLY GUARANTEE RESULTS. I ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE BY ANYONE REGARDING THE DENTAL TREATMENT WHICH I HAVE REQUESTED AND AUTHORIZED. (INITIALS: _____)

I HEREBY AUTHORIZE ANY OF THE DOCTORS OR DENTAL AUXILIARIES TO PROCEED WITH AND PERFORM THE DENTAL RESTORATIONS AND TREATMENTS AS EXPLAINED TO ME. I UNDERSTAND THAT THIS IS ONLY TO MODIFICATION DEPENDING ON UNFORESEEN OR UNDIAGNOSABLE CIRCUMSTANCES THAT MAY ARISE DURING THE COURSE OF TREATMENT. I UNDERSTAND THAT REGARDLESS OF ANY DENTAL INSURANCE COVERAGE I MAY HAVE. I AM RESPONSIBLE FOR PAYMENT OF THE DENTAL FEES. I AGREE TO PAY ANY ATTORNEY'S FEES, OR COURT COSTS, THAT MAY BE INCURRED TO SATISFY THIS OBLIGATION. (INITIALS: _____)

THE UNDERSIGNED HEREBY AUTHORIZES THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTICS AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S NEEDS. I ALSO AUTHORIZE THE DOCTOR TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY THAT MAY BE INDICATED. I ALSO UNDERSTAND THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK. I UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN ME AND THE INSURANCE CARRIER, AND NOT BETWEEN THE INSURANCE CARRIER AND THE DOCTOR AND THAT I AM STILL FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME SERVICE IS RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO THE DOCTOR. ANY PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT, OR REFUNDED TO THE DOCTOR. ANY PAYMENT RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT, OR REFUNDED TO ME IF I HAVE PAID THE DENTAL FEES INCURRED. I UNDERSTAND THAT MY ESTIMATED TREATMENT CAN BE CHANGED DURING THE COURSE OF THE TREATMENT DEPENDING ON CLINICAL NEEDS WE OBTAIN THE RIGHT TO CHARGE ($25.00) FOR BROKEN APPOINTMENTS OR CANCELLED APPOINTMENTS WITH OUT 24 HOUR NOTICE.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

_____ _____

DENTIST SIGNATURE DATE

OUR FINANCIAL POLICY

TO AVOID ANY POSSIBLE MISUNDERSTANDINGS REGARDING PAYMENTS FOR SERVICES RENDERED, WE ARE PROVIDING YOU WITH THIS STATEMENT OF OUR FINANCIAL POLICY.

PAYMENT IS DUE AT THE TIME OF SERVICES ARE RENDERED. WE ACCEPT CASH AND MAJOR CREDIT CARDS FOR YOUR CONVENIENCE.

1. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE **NOT** A PARTY TO THAT CONTRACT. IT IS YOUR RESPONSIBILITY TO KNOW AND UNDERSTAND YOUR INSURANCE POLICY INCLUDING ITS EXCLUSION AND LIMITATIONS, PLEASE NOTE: YOUR INSURANCE COVERAGE MAY CHANGE WHEN HAVING TREATMENT PERFORMED BY A SPECIALIST.
2. ALL CHARGES ARE YOUR RESPONSIBILITY, WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. NOT ALL SERVICES ARE COVERED BENEFIT IN ALL CONTRACTS. PLEASE UNDERSTAND THAT OUR PATIENTS HAVE HUNDREDS OF DIFFERENT POLICIES AND IT IS IMPOSSIBLE TO KEEP UP-TO-DATE OF EVERYONE'S CHANGES AND COVERAGE. WE WILL DO OUR BEST TO ASSIST YOU.
3. FEES FOR SERVICES, ALONG WITH UNPAID DEDUCTIBLE AND CO-PAYMENTS ARE DUE AT THE TIME OF TREATMENT. WE **ESTIMATE** THESE PAYMENTS FOR YOU, GIVEN THE INFORMATION AVAILABLE, IF AFTER PAYMENT FROM YOUR INSURANCE COMPANY IS RECEIVED AND A BALANCE REMAINS ON YOUR ACCOUNT, OUR OFFICE WILL SEND YOU A BILL. PLEASE DO NOT WAIT UNTIL YOUR NEXT APPOINTMENT TO PAY BALANCE DUE. PAYMENT IS DUE UPON RECIEPT OF YOUR STATEMENT.
4. FEES QUOTED FOR SERVCES ARE GOOD FOR 3 (THREE) MONTHS AND MAY CHANGE AFTER THAT TIME.
5. PARENTS OR GUARDIANS ARE RESPONSIBLE FOR FEES INCURRED BY MINOR CHILDREN ON THE DAY SERVICES ARE RENDERED.

PAYMENT OPTIONS

YOU CAN CHOOSE FROM:

CASH, VISA®, MASTERCARD®, AMERICAN EXPRESS® AND DISCOVER®,

WE OFFER COURTESY ACCOUNTING ADJUSTMENT TO PATIENTS WHO PAY THEIR TREATMENT PRIOR TO THEIR INTIAL TREATMENT.

- 5% CASH
- 4% CASHIERS CHECK OR MONEY ORDER (RETURN CHECK FEE $35.00)
- 3% MAJOR CREDIT CARDS

CONVENIENT MONTHLY PAYMENTS OPTIONS FROM **CARECREDIT® HEALTHCARE CREDIT CARD AND LENDING CLUB PATIENT SOLUTIONS.**

- ALLOW YOU TO PAY OVER TIME
- NO ANNUAL FEES OR PRE-PAYMENT PENALTIES

PLEASE NOTE THAT OUR OFFICE REQUIRES PAYMENT AT THE BEGINNING OF TREATMNENT. IF YOU CHOOSE TOO DISCONTINUE CARE BEFORE TREATMENT IS COMPLETE, YOU WILL RECEIVE A REFUND LESS THE COST OF THE CARE RECEIVED.

FOR PATIENTS WITH DENTAL INSURANCE WE ARE HAPPY TO WORK WITH YOUR CARRIER TO MAXIMIZE YOUR BENEFITS AND DIRECTLY BILL FOR REIMBURSEMENT FOR YOUR TREATMENT.

IF YOU HAVE ANY QUESTIONS PLEASE DO NOT HESITATE TO ASK.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

PATIENT CONSENT TO USE OF SURVEILLANCE CAMERAS

THIS DOCUMENT (THE AGREEMENT) CONTAINS IMPORTANT INFORMATION ABOUT OUR PROFESSIONAL SERVICES AND BUSINESS POLICIES AT PARAMOUNT SMILES. IT ALSO CONTAINS SUMMARY INFORMATION ABOUT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), A FEDERAL LAW THAT PROVIDES PRIVACY PROTECTIONS AND PATIENT RIGHTS WITH REGARD TO THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI) USED FOR THE PURPOSE OF HEALTH CARE OPERATIONS. HIPAA REQUIRES THAT WE PROVIDE YOU WITH A NOTICE OF PRIVACY PRACTICES (THE NOTICE) FOR USE AND DISCLOSURE OF PHI FOR HEALTH CARE OPERATIONS. WHEN YOU SIGN THIS DOCUMENT, IT WILL ALSO REPRESENT AN AGREEMENT BETWEEN YOU AND PARAMOUNT SMILES. YOU MAY REVOKE THIS AGREEMENT IN WRITING AT ANY TIME.

PARAMOUNT SMILES USES SURVEILLANCE VIDEO CAMERAS IN ITS COMMON AREAS, INCLUDING BUT NOT LIMITED TO THE EXTERIOR OF THE BUILDING, WAITING ROOM, RECEPTIONS AREA, HALL WAYS, OPERATORIES AND X-RAY AREAS. SURVEILLANCE EQUIPMENT WILL NEVER BE USED IN PRIVATE SPACES, SUCH AS RESTROOMS OR DOCTORS' OFFICES. THE CAMERAS RUN CONTINUOUSLY, 24 HOURS PER DAY, SEVEN DAYS A WEEK. THE DVR DEVICE THAT RECORDS THE VIDEO IS ONLY ACCESSIBLE BY THE OWNERS OF THE DENTAL OFFICE. ONCE THE DVR MEMORY IS FULL, IT WILL RECORD OVER THE OLDEST RECORDED MATERIAL, THEREBY DESTROYING THE OLD MATERIAL. DR. SHAPIRO, WILL MAINTAIN THE CAMERAS AND VIDEO EQUIPMENT AND ENSURE THAT THEY ARE FUNCTIONING PROPERLY. ONLY DR. SHAPIRO IS AUTHORIZED TO REVIEW THE RECORDED MATERIAL. THERE MAY ARISE SITUATIONS WHEREIN THE RECORDED MATERIAL IS NECESSARILY USED IN THE REPORTING AND INVESTIGATION OF THEFT, ASSAULT, AND OTHER REPORTABLE INCIDENTS. DURING THESE INVESTIGATIONS, YOUR PRIVACY AS A PATIENT MAY BE COMPROMISED. IF THE RECORDED MATERIAL IS EVER USED IN THE REPORTING AND INVESTIGATION OF REPORTABLE INCIDENTS, DOCUMENTATION WILL BE MADE OF THE PERSONS WHO VIEW THE RECORDED SEGMENTS AND THEIR CREDENTIALS. ALSO, ALL PATIENTS VISIBLE IN THE REVIEWED SEGMENTS OF RECORDED MATERIAL WILL BE NOTIFIED THAT THEY WERE PRESENT IN THE VIEWED SEGMENTS AND GIVEN THE NAMES OF ALL PERSONS WHO VIEWED THE SEGMENTS. DR. SHAPIRO WILL CONTINUOUSLY MONITOR THE SURVEILLANCE POLICIES AND PROCEDURES TO REDUCE THE RISK OF BREECHES OF PRIVACY.

CONSENT

I, A PATIENT OF PARAMOUNT SMILES, UNDERSTAND THAT IN ORDER TO PROMOTE THE SAFETY OF EMPLOYEES AND PATIENTS, AS WELL AS THE SECURITY OF ITS FACILITIES, PARAMOUNT SMILES MAY CONDUCT VIDEO SURVEILLANCE OF ANY PORTION OF ITS PREMISES AT ANY TIME, WITH THE EXCEPTION OF RESTROOMS AND DRESSING ROOMS IF ANY ON PREMISES. ALL VIDEO CAMERAS WILL BE POSITIONED IN APPROPRIATE PLACES WITHIN AND AROUND PARAMOUNT SMILES PREMISES AND USED IN ORDER TO HELP PROMOTE THE SAFETY AND SECURITY OF PEOPLE AND PROPERTY. I HEREBY GIVE MY CONSENT TO SUCH VIDEO SURVEILLANCE AT ANY TIME THE COMPANY MAY CHOOSE.

I HEREBY RELEASE LARRY L. SHAPIRO, DDS, P.A. AND PARAMOUNT SMILE FROM ALL LIABILITY, INCLUDING LIABILITY FOR NEGLIGENCE, ASSOCIATED WITH THE ENFORCEMENT OF THESE POLICIES AND/OR ANY SEARCHES OR SURVEILLANCE UNDERTAKEN PURSUANT TO THESE POLICIES.

_____	_____	_____
SIGNATURE PARENT / GUARDIAN	PRINT NAME	DATE

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION
FROM OTHER HEALTHCARE FACILITIES

Patient Name:_____ SS#:_____

Telephone #:_____ Date of Birth: _____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Name of Healthcare Facility from which Records are Requested:

_____ Ph: _____ Fax: _____

(Please Print)

Address:_____ City:_____ State:_____ Zip:_____

Dates of Treatment Requested: _____ Reason for Disclosure: _____

MAIL INFORMATION TO: **PARAMOUNT SMILE**
1500 N UNIVERSITY DRIVE STE 111 CORALSPRINGS, FL 33071

Or FAX TO: **954.753.0520** Or Email To: info@paramountsmile.com

I hereby authorize **PARAMOUNT SMILE. , (PS)** to obtain the health information indicated below that is contained in my patient records to the Recipient named above.

AND for the purpose of alternative means of confidential communication the use of their Email Address.

PX offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **PX** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **PX** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and consent to the conditions outlined herein. Any questions I may have had were answered.

Check a Box ☑

	Complete Record		Radiology Reports
	Lab Reports		Pathology Reports
	Other (Specify)		Other (Specify)

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box (es) below:

☐ Drug/ Alcohol Abuse or Treatment ☐ HIV/ AIDS Test Results or diagnoses ☐ Genetic Testing Information

☐ Psychotherapy Notes (The release of Psychotherapy Notes required a separate authorization)

This consent is subject to revocation at any time except to the extent the action has been taken thereon**. This authorization and consent will expire one year from the date of authorization written below.**

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____ Date Signed: _____/_____/_____

Signature of Patient or Legal Representative

Printed Name: _____ Relationship if not Patient: _____

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. **For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ SS#: _____

Telephone #: _____ Date of Birth: _____/ _____/ _____

Address: _____

I authorize **PARAMOUNT SMILE., (PS)** to release the health information indicated below to:

Person/ Organization:

_____

Address:_____ Phone: _____

AND for the purpose of alternative means of confidential communication the use of the following Email Address:

PS offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **PS** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **PS** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and I consent to the conditions outlined herein. Any questions I may have had were answered.

Dates of Medical Record Release:

_____

Reason for Disclosure:

____ Continuing Care ____ Insurance _____ Legal _____ Personal Use _____ Other Reason

Check a Box ☑

	Complete Record		Radiology Reports
	Lab Reports		Pathology Reports
	Other (Specify)		Other (Specify)

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Printed Name

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