VERO BEACH ART OF DENTISTRY

Personal Identification-

Last Name: _____ First Name: _____ Middle: _____

Name you prefer to be called: _____ Title: ❑ Mr. ❑ Mrs. ❑ Miss. Other: _____

Street Address: _____ City: _____

State:_____ Zip: _____ Home Phone: (_____)_____ Year-Round Resident: ❑ Yes ❑ No

Work Phone: (_____)_____ Cell Phone: (_____)_____

I prefer to be contacted at my: ❑ Home number ❑ Work number ❑ Cell number Email:_____

Gender: ❑ Male ❑ Female Marital Status: ❑ Divorced ❑ Married ❑ Single ❑ Separated ❑ Widowed

Birth date:_____ Soc. Sec. #: (only if you have insurance)_____

Party Responsible for Payment: ❑ Self ❑ Spouse ❑ Parent ❑ Caregiver ❑ Other _____

Name of Responsible Party:_____ Signature: _____

Who referred you to our office? _____

Insurance Information

Dental Insurance Company (if applicable): _____Group/ID #:_____

Address: _____Phone: (_____)_____

Subscriber: ❑ Self ❑ Spouse ❑ Parent ❑ Other Subscriber Name: _____ DOB:_____ SS#:_____

We are a fee for service practice. Payment is due at time of service unless other arrangements are made. We will provide all necessary dental forms needed to help you obtain reimbursement from your dental insurance company.

Employment Status

Employer (School if student): _____Title (Major if student):_____

Employer/School Address: _____

Emergency Contact Information

Emergency Contact Name:_____ Relationship: _____

Emergency Contact Phone Number: (_____)_____

Medical Information

Primary Care Physician's Name: _____ Phone: (_____)_____

Are you under a physician's care now? ❑ Yes ❑ No Reason:_____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No Reason: _____

Please list any medications you are currently taking:

Medication	Reason	Medication	Reason

Do you use tobacco? ❑ Yes ❑ No Type: _____ Are you currently pregnant? ❑ Yes ❑ No

Do you have any known allergies? ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Latex ❑ Sulfa ❑ Other_____

Do you have, or have you had, any of the following?

❑ AIDS/HIV Positive	❑ Cold Sores/Fever Blisters	❑ Glaucoma	❑ Herpes	❑ Radiation Treatment
❑ Alzheimer's Disease	❑ Congenital Heart Disorder	❑ Hay Fever	❑ High Blood Pressure	❑ Rheumatic Fever
❑ Anemia	❑ Diabetes	❑ Heart Attack/Failure	❑ Hypoglycemia	❑ Scarlet Fever
❑ Angina	❑ Emphysema	❑ Heart Murmur	❑ Irregular Heartbeat	❑ Sinus Trouble
❑ Artificial Heart Valve	❑ Epilepsy/Seizures	❑ Heart Pacemaker	❑ Kidney Problems	❑ Tuberculosis
❑ Artificial Joint	❑ Excessive Bleeding	❑ Heart Trouble/Disease	❑ Liver Disease	❑ Yellow Jaundice
❑ Cancer	❑ Fainting Spells	❑ Hepatitis A	❑ Mitral Valve Prolapse	❑ Hepatitis C
❑ Chemotherapy	❑ Frequent Headaches	❑ Hepatitis B	❑ Pain in Jaw Joints	

Have you had any serious illness not listed above? _____

Do you take antibiotics before dental work? ❑ Yes ❑ No Reason: _____

Prescribing Doctor: _____ Phone: (_____)_____

Type prescribed: _____Dosage: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Do you see another dentist for cleanings? Dentist: _____ Frequency: _____

Address: _____ Phone: (_____)_____

Patient Signature: _____ Date: _____

VERO BEACH
Art OF DENTISTRY

Appointment Change and Cancellation Policy

Appointments are considered confirmed when they are made. Our office requires two business days notice for appointment change requests. This includes requests for changes in time, date, treatment, provider, or appointment cancellation. Please note that should you leave a request for change on our voicemail when the office is closed, we will consider the request to have been made on the following business day.

Should you fail to give the required two business days notice for appointment changes, you will be charged a fee. This fee could be up to and including the full fee for the appointment you changed, cancelled, or missed.

I have read and understand the Appointment Change and Cancellation Policy.

_____ _____

Sign Date

M. Johnson Hagood, DDS, PA 2155 Ponce De Leon Circle Vero Beach, FL 32960 Phone: (772) 567-2237 Fax: (772) 567-1052 www.verobeachartofdentistry.com

VERO BEACH
Art OF DENTISTRY

M. Johnson Hagood, DDS
Informed Consent and Treatment Confirmation

Patient's Name: _____ Date _____

To my knowledge I have given an accurate report of my health history. Any prior allergic or unusual reactions, gum or skin reactions, abnormal bleeding and any other conditions related to my health are included.

I have been informed and understand that occasionally there are complications from treatment and local anesthesia. Complications can include but are not limited to: pain, swelling, sensitivity, gum discoloration, bruising, infection, drug/anesthetic reactions and side effects, damage to adjacent teeth or fillings, post-treatment bleeding, failure of the dental treatment procedure necessitating additional treatment, and complications during treatment necessitating referral to a specialist.

I understand that photos, radiographs, and other records may be made during the course of my examination, treatment and follow-up care. I give my permission for such items to be used for purposes of education, research, or publication in professional journals or websites. I understand my identity will not be revealed (by name). Please indicate if no full facial photos may be used during educational programs by checking here. ☐

After an oral exam performed by Dr. Hagood and with full understanding after discussion of all aspects of my dental treatment including potential modifications, I approve treatment as outlined by the doctor or his associates. I certify that I have read and understand all of this INFORMED CONSENT which outlines the general treatment considerations as well as the potential problems and complications of Restorative/Prosthodontic treatment. I understand that potential complications and problems may include, but are not limited, to those described in this document. I have been given the opportunity to ask questions about the proposed treatment and associated risks, as well as the potential consequences should I elect to postpone or refuse to implement care. I will be given an estimate and explanation of all fees associated with my treatment before treatment begins. I understand that conditions may occur during and following treatment that warrant additional or alternative care. I further understand that no guarantees can be made for a successful result.

Signed _____ Date _____

Relationship if patient is a minor:_____

Witness _____ Date _____

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 to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, 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 2/15/2005, 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 law. We reserve the right to make the changes in our privacy practices and in the new terms of our notice effective for all health information that we maintain, including health information that 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 Kelly Barrett at (772) 567-2237.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

- ◊ ***Treatment***: We may use or disclose your health information to a physician or other healthcare providers providing treatment to you
- ◊ ***Payment***: We may use or disclose your health information to obtain payment for services we provide to you
- ◊ ***Healthcare Operations***: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare 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, and healthcare 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 affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

To Your Family and Friends: We must disclose your health information to you, as described in the Patient 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 with your healthcare or payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Your Care: We may use or disclose 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 of 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 healthcare. 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 the health or 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 inmate or patient under certain circumstances.

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 that you request unless we cannot 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 in this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter at our office. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.
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, or healthcare operations and certain other activities, for the last 6 years, by not before February 15, 2005. 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 explanation 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions, 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 alternative locations, you may complain to Dr. M. Johnson Hagood at (772) 567-2237. 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.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices which describes how my health information may be used or disclosed.

Print Name	Signature	Date

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 (specify) _____

Directions to Dr. Hagood's Office

From the South via US 1: Take US 1 North. Pass the Miracle Mile area. Make a right at the light of US 1 and 11th Ave./Ponce De Leon Circle (Patio Restaurant and Texaco station on the corners). Immediately bear left at the fork (Royal Park West Apartments will be on your right.) Office is a tan building, next to Greens Plus, behind the Texaco station.

From the North via US 1: Take US 1 South. Pass the airport area. Make a left at the light of US 1 and 11th Ave./Ponce De Leon Circle (Patio Restaurant and Texaco station on the corners). Immediately bear left at the fork (Royal Park West Apartments will be on your right.) Office is a tan building, next to Greens Plus.

From the South via Indian River Blvd.: Take Indian River Blvd. North. Pass the 17th Street Bridge. Make a left at the light at Royal Palm Blvd. Pass Trinity Church on your right. Make the next left onto Ponce De Leon Circle. Office is tan building on your right, next to Greens Plus, across from Royal Park West Apartments.

From the North via Indian River Blvd.: Take Indian River Blvd. South. Pass the Merrill Barber Bridge. Make a right at the light onto Royal Palm Blvd. Pass Trinity Church on your right. Make the next left onto Ponce De Leon Circle. Office is tan building on your right, next to Greens Plus, across from Royal Park West Apartments.

From the West via Rt. 60: Take Rt. 60 East through Downtown Vero. Make a left onto 11th Ave. (East Coast Lumber on the corner). Go thru two lights. 11th Avenue turns into Ponce De Leon Circle. Bear left at the fork (Royal Park West Apartments will be on your right.) Office is a tan building, next to Greens Plus.

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