North Naples Dental

Laura Van Varick, D.D.S.

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 by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our 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 4/15/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices ant the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our policy 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 us using the information at the end of this Notice.

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 physician/dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided to you.

Your Authorization: In addition to our use of your health information for treatment, payment or 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 authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we can not use or disclose your health information for any reason except those described in this Notice.

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 with payment of your healthcare, but only if you agree that we may do so.

Person Involved In 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 the 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 persons 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. We may from time to time contact you by mail or phone to update you on information that may be pertinent to your dental health unless you state in writing otherwise.

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

Abuse or Neglect: We may disclose your health information to the 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 the 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Correspondence: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.), birthday cards, or recall cards, and missed appointment notification.

Patient Rights:

Access: You have the right to look or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other that photocopies. We will use the format 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 on the front of 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 to the address on the front of this Notice. If you request copies, we will charge you for duplication of your records and x-rays.

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, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

Restrictions: 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 .

I have read and understand the above information.

Patient Signature_____ **Date**_____

Medical History **Laura Van Varick, D.D.S.**

Patient Name:_____ Date:_____

Are you currently under the care of a physician? _____Yes _____No
Physician Name _____ Phone_____
Address_____
Have you ever been hospitalized or had surgery? _____Yes _____No
Please discuss_____
_____
Do you know of any allergies to the following? Check all that apply:

___Penicillin ___Latex
___Sulfa ___Codeine
___Erythromycin ___Aspirin/Ibuprofen
___Tetracycline ___Metals
___Dental Anesthetics ___Other_____

Women: Are you pregnant? ___Yes ___No Nursing? ___Yes ___No
Taking Birth Control Pills? ___Yes ___No

Have you had any of the following diseases or medical problems? Check all that apply:

___Heart Problems	___Diabetes	___Cancer (type:_____)
___Chest Pain	___Kidney Problems	___Chemotherapy
___Congenital Heart Disease	___Liver Problems	___Radiation Therapy
___Heart Murmur	___Hepatitis A B C D	___AIDS
___Mitral Valve Prolapse	___Ulcers	___HIV+
___Artificial Heart Valve	___Glaucoma	___Venereal Disease
___Bacterial Endocarditis	___Emphysema	___Cold Sores/Fever Blisters
___Pacemaker	___Chronic Cough	___Hemophilia
___High Blood Pressure	___Tuberculosis	___Blood Transfusion
___Low Blood Pressure	___Asthma	___Sickle Cell Disease
___Rheumatic Fever	___Hay Fever	___Abnormal Bleeding
___Arthritis/Rheumatism	___Allergies or Hives	___Epilepsy/Seizures
___Stroke	___Thyroid Problems	___Fainting/Dizzy Spells
___Artificial Joint (hip, knee, etc.)	___Sinus Problems	___Drug Abuse
___Lupus	___Smoker (past or present)	___Alcohol Abuse
___Neurological Disorders	___Smokeless Tobacco	___Psychiatric Problems

___Other_____

Please List all **Medications**, **Vitamins**, and **Nutritional Supplements** that you are currently taking:

Medication	Dosage	Reason	Medication	Dosage	Reason

I understand that this medical history is a legal document and that I have answered all the questions to the best of my ability and knowledge and I will not hold my dentist or any other staff members responsible for any errors or omissions I have made in the completion of this form.

Signature of Patient or Legal Guardian _____

Doctor Notes

Patient Registration **Laura Van Varick, D.D.S.**

Last Name_____ **First**_____ **Nickname**_____
If Child: Parent/Guardian Name_____
Address_____
City_____ **State**_____ **Zip**_____ **Male**___ **Female**___
Birthdate_____ **SS#**_____ **Marital Status**_____
Phone: Home(____)_____ **Email**_____
Cell (____)_____ **Employer**_____
Work (____)_____ **Occupation**_____
At which number to you wish to be contacted? ___Home ___Cell ___Work
Emergency Contact:_____ **Phone**_____

How did you hear about our office?_____

Dental Insurance Company_____ Subscriber_____
Subscriber's Employer_____ Group #_____

Seasonal Resident?___Yes___No Northern Address_____

City_____ State_____ Zip_____ Phone_____
Approximate Dates of Naples Residence_____

Authorization

I authorize Dr. Van Varick to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another health care professional or to the emergency contact in the event of an emergency. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts.

Signature_____ **Date**_____

Dental History

Purpose of today's visit?_____
Last Dental Cleaning_____ Last Dental Exam/Xrays_____
How do you rate your current dental health? ___Good ___Fair ___Poor
Do you have any dental problems/concerns now? ___Yes ___No
If yes please describe: _____
How often do you brush your teeth?_____ Floss?_____
Check all that apply:

____Grind/Clench teeth ____Bad breath
____Jaw Pain ____Bleeding Gums
____Previous Orthodontics ____Teeth sensitive to Hot/Cold
____Growths/Sores in mouth ____Teeth sensitive to Sweets
____Previous Periodontal Treatment, if yes when?_____

Do you feel nervous about having dental treatment? ____Yes ____No
If yes, please explain_____
Are you happy with the appearance of your smile? ____Yes ____No
If no, what would you change?_____
Is there anything we can do to make your visit more comfortable?_____
_____

North Naples Dental

OFFICE AND FINANCIAL POLICY

- Payment is due at the time of treatment unless other arrangements were made prior to starting procedure.
- All treatment plans will be honored for 30 days in the event that fees change.
- Insurance companies will not guarantee benefits over the phone or internet. The insurance portion of all treatment plans are only an estimate. Any unpaid insurance balance is ultimately the patients responsibility.
- All minor children, under the age of 18, must be accompanied by a parent or legal guardian for the entire time they are receiving dental treatment.
- There will be a charge of $25.00 per hour/per scheduled appointment if an appointment is canceled without a minimum of 24 hours notice.
- We reserve the right to reschedule a patient if you are 15 minutes or more late for your scheduled appointment time.

We know that your time is valuable, as is ours. We will do our best to see each patient promptly at their scheduled appointment time but we want our patients to understand that from time to time an emergency may arise that will cause us to run late for the next scheduled patient appointment. We will inform you of the delay and if it is necessary for you to reschedule we will schedule your appointment back at the soonest available time. We truly appreciate your understanding.

Signature: _____ Date:_____