



Walter F. Zoller, D.M.D., P.A.

Welcome!

Dr./Mr./Mrs./Miss/Ms.?? _____

Name: _____ Birthdate: _____ Social Security #: _____

Address: _____ City: _____ St: _____ Zip Code: _____

Phone #: _____ Cell Phone #: _____ e-mail: _____

Employer: _____ Business Phone#: _____ Ext#: _____

Preferred Pharmacy: _____ Location: _____ Phone #: _____

Parent/Guardian Information:

Name: _____ Birthdate: _____ Social Security #: _____

Address (if different from above) : _____ City/State/Zip: _____

Insurance Information:

Primary Dental Insurance Employer: : _____ Dental Insurance Co: _____

Insurance Phone #: _____ Insurance Group #: _____ SS# or Insurance ID#: _____

Insured Employee: _____ Employee Date of Birth: _____

Secondary Dental Insurance Employer: : _____ Dental Insurance Co: _____

Insurance Phone #: _____ Insurance Group #: _____ SS# or Insurance ID#: _____

Insured Employee: _____ Employee Date of Birth: _____

General Information:

Who May We Thank for Recommending You? – How Did You Hear About Us? _____

Purpose of Today's Visit? _____

"We would like to get to know you Better!"

WALTER F. ZOLLER, D.M.D., P.A

Name _____ How would you liked to be addressed? _____

e-Mail Address: _____

Have you visited our Website? _____ www.AdvancedDental-PSJ.com

PLEASE ANSWER ALL QUESTIONS - AS THEY ARE VERY IMPORTANT.

CIRCLE "YES" or "NO", AND ADD MORE SPECIFIC NOTATIONS IN THE SPACES PROVIDED

DENTAL HISTORY:

1. Are you having any discomfort at this time? ... Yes No Comments? _____

2. Have you ever had any serious trouble associated with previous dental treatment? Yes No

If so, explain _____

3. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

4. Date of last dental visit _____ For what reason? _____

5. How often do you brush? _____ Brush is : Soft _____ Medium _____ Hard _____

Power Brush?Yes No Which Product? _____ How Long in Use? _____

Dental Floss? Yes No Which Product? _____ How often? _____

Water Pik/Oral Irrigator? Yes No Which Product? _____ How often? _____

Oral Health Rinses? Yes No Which Product? _____ How often? _____

6. ORAL HEALTH:

Bleeding, sore gums? Yes No Sensitive to cold? Yes No

Unpleasant taste/bad breath? Yes No Sensitive to hot? Yes No

Frequent blisters, lips/mouth? Yes No Loose teeth? Yes No

Sensitive to biting? Yes No Do spaces between your teeth annoy you? .. Yes No

Clicking/popping jaw? Yes No Any teeth stained, cracked/chipped? Yes No

Difficulty opening/closing jaw? Yes No Do you have any crooked teeth? Yes No

Clenching/grinding of jaws/teeth? Yes No Are you concerned about your breath? Yes No

Would you like to have whiter teeth? Yes No Would you like to have fresher breath?..... Yes No

7. When you look in the mirror, do you LIKE the appearance of your teeth?..... Yes No

8. FURTHER COMMENTS ABOUT THE ABOVE QUESTIONS? _____

MEDICAL HISTORY:

1. The name and address of my physician is: _____

2. My last visit to a physician was _____ For what reason? _____
3. Have you had any serious illness within the past five (5) years?Yes No
If so, what was the illness? _____
4. Have you been hospitalized or had an operation within the past five (5) years?Yes No
If so, what was the problem? _____
5. Do you have or have had any of the following diseases or problems?
 - a. Rheumatic Fever or Rheumatic Heart disease?Yes No
 - b. Mitral Valve ProlapseYes No With or without regurgitation? _____ Don't know _____
 - c. Heart/Cardiovascular History?? (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, heart wall/septum defect, etc.) Yes No
Heart Murmur.....Yes No Functional? _____ Non-Functional? _____ Don't know _____
Pain in the chest upon exertion?..... Yes No Shortness of breath upon exercise?..... Yes No
 - d. Artificial/Replacement valves?..... Yes No Pacemaker? Yes No
Comments? Other heart ailments not mentioned? _____
 - e. Sinus Trouble?..... Yes No Hay Fever? Yes No
 - f. Asthma or other Lung Disease? Yes No Comments: _____
 - g. Diabetes?Yes No Medication? _____ Dosage/Frequency? _____
Hypoglycemia? ... Yes No Hyperglycemia? .. Yes No Medication? _____ Dosage/Frequency? _____
 - h. Ulcers/Stomach Disorders?Yes No Comments: _____
 - i. Hepatitis, Jaundice - other Liver Disease?..Yes No Comments: _____
 - j. Thyroid Disorder?Yes No Type? _____ Medication/Dosage? _____
 - k. Epilepsy - Seizure Disorder?Yes No Medication? _____ Dosage/Frequency? _____
 - l. Allergies? Which of the following are you allergic to? (Please Circle) **NO KNOWN ALLERGIES!**
Local Anesthetics Penicillin or other antibiotics - which one(s)? _____ Sulfa Drugs
Latex Barbituates/other sleeping agents - which one(s)? _____
Aspirin Ibuprofen or other antinflammatory agents - which one(s)? _____
Codeine Darvon **Other Allergies not mentioned?** _____
 - m. Artificial or Replacement Joints? Yes No Any Episodes of Infection in this Prosthetic Joint? ...Yes No
 - o. Pins through any Joint?..... Yes No When Placed?: _____
 - p. Kidney Trouble? Yes No Comments: _____
 - q. Tuberculosis? Yes No Comments: _____
 - r. Arthritis? Yes No Medication? _____ Dosage/Frequency? _____
 - s. Immune Disorders? (Lupus, HIV,AIDS) ... Yes No Comments: _____
 - t. Blood Disorder, such as Anemia? Yes No Comments: _____

HEALTH AND DENTAL HISTORY QUESTIONNAIRE

Name: _____

6. Have you had a Growth or Tumor that required X-Ray Treatment or Surgery? Yes No

Comments: _____

7. Are you HIV Positive? Yes No

8. Have you ever used the Prescription Diet Aids — Phen-Fen or Redux? Yes No

9. Do you smoke cigarettes?Yes No How many packs per day? _____

Other tobacco products?Yes No What type and how often? _____

10. Do you use any alcohol products?Yes No How much per day/week/month and what? _____

11. Do you use any caffeinated products such as coffee, tea, chocolate or sodas?Yes No

If so, how much per day and what? _____

12. Do you have a history of substance abuse?Yes No Substance(s)? _____

Current Restrictions? _____ Comments? _____

13. Are you taking any of the following? (Please Circle)

Antibiotics Sulfa Drugs Blood Pressure Medication(s): (type and dosage): _____

Blood Thinners Steroids Ritalin Antidepressants Tranquilizers Nitroglycerin

Heart Medication(s): (type and dosage) _____ Aspirin Antihistamines

Anti-Inflammatory Agents (Ibuprofen, Anaprox, etc.) Tagament/Zantac Hormones

Other Medications not mentioned? _____

14. WOMEN:

a. Are you Pregnant?Yes No When is your approximate due date? _____

b. Do you have PMS or other problems associated with your menstrual period?Yes No

c. Are you on Birth Control Therapy? Yes No or Hormone Therapy?Yes No

15. Do you have any other disease, condition, or problem not listed, that you think we should know about?.....Yes No

Please explain: _____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT.
IF I EVER HAVE ANY CHANGE IN MY HEALTH HISTORY OR CHANGE IN MY MEDICATION,
I WILL INFORM *ADVANCED DENTAL CARE* AT MY NEXT APPOINTMENT!

Photography Permission: I hereby give Dr. Walter F. Zoller the absolute right and permission to use my photographs/slides for educational or promotional purposes [minus any noted exceptions]. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.



Signature of Patient (Parent)

Date

Advanced Dental Care

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.

{Please 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 (Please Specify)

Protected Health Information Release Form

In compliance with HIPAA regulations, and in order to facilitate requests for your *Protected Health Information*, please complete this permission form.

I authorize the person(s) listed below to have access to any of my (or my minor child indicated) protected health information (which may include allergies, HIV status, and medications being taken). Advanced Dental Care/Walter F. Zoller, D.M.D, P.A. is permitted to share this information, along with test results and information disclosed during my (or my minor child indicated) office visits. For copies of dental records, I understand that I will need to sign a separate authorization.

Please list below those individual(s) that may view this information:

(e.g. Spouse, Parent, 'significant other' - domestic partner)

Full Name

Relationship

Full Name

Relationship

Full Name

Relationship

Communication Release

Advanced Dental Care/Walter F. Zoller, D.M.D., P.A. is authorized to communicate my (or my minor child indicated) appointment confirmations and other non-clinical information in the following manner:

- (please check) _____ Leaving Messages on my answering machine/voice mail at work
_____ Leaving Messages with a co-worker at place of employment
_____ Leaving Messages on my answering machine/voice mail at home
_____ Leaving Messages on my cell phone/pager/voice mail
_____ Other Forms of Communication - _____

I understand that this authorization will remain in effect until it is revoked by me in writing.

Patient Name (please print)

Patient (Parent) Signature

Relationship to Patient

Witness Name (please print)

Witness Signature

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

For purposes of this Notice “us” “we” and “our” refers to Walter F. Zoller, D.M.D., P.A. and “you” or “your” refers to our patients (or their legal representatives as determined by us in accordance with Florida informed consent law). When you receive health-care services from us, we will obtain access to your medical information (e.g., your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so. Florida law and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) require us to maintain the confidentiality of all your health-care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally (“PHI” or Protected Health Information). HIPAA is a federal law that gives you significant new rights to understand and control how your health information is used. HIPAA and Florida law provide penalties for covered entities and records owners, respectively, that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with this Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. Our doctor(s), clinical staff, Business Associates (outside contractors we hire), employees and other office personnel follow the policies and procedures set forth in this notice. If your regular doctor is unavailable to assist you (e.g. illness, on-call coverage, vacation, etc.), we may provide you with the name of another health-care provider outside our practice for you to consult with by telephone. If we do so, that provider will follow the policies and procedures set forth in this notice or those established for his or her practice, so long as they substantially conform to those for our practice.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law (§456.074, Fla. Stats., and HIPAA), we must have your signature on a written, dated Consent form and/ or an Authorization form (not an Acknowledgment form) before we will use and disclose your PHI for certain purposes as detailed in the rules below.

Documentation You will be asked to sign a Consent form and/or an Authorization form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our privacy officer. You may take back or revoke your Consent or Authorization at any time (unless we already have acted based on it) by submitting our Revocation form in writing to us at our address listed below. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation.

General Rule If you do not sign our **Consent** form or if you revoke it, as a general rule (subject to exceptions described below under “Healthcare Treatment, Payment and Operations Rule” and “Special Rules”), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. **Under Florida law, we are unable to submit claims to payers under assignment of benefits without your signature on our Consent form.** We will not condition treatment on your signing an Authorization, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or revoke it.

Health-care Treatment, Payment and Operations Rule With your signed Consent, we may use or disclose your PHI in order:

- To provide you with or coordinate health-care treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other health-care providers, schedule lab work for you, etc.
- To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your X-rays because your health plan requires them for payment; or
- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your telephone or e-mail to contact us. We may call you by name from the reception room. We may tell you about or recommend health-related products and complementary or alternative treatments that may interest you. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us.

Special Rules Notwithstanding anything else contained in this Notice, only in accordance with applicable law, and under strictly limited circumstances, we may use or disclose your PHI without your permission, Consent or Authorization for the following:

- When required under federal, state or local law;
- When necessary in emergencies to prevent a serious threat to your health, safety or the health & safety of other persons;
- When necessary for public health reasons (e.g., prevention or control of disease, injury or disability; reporting information such as adverse reactions to anesthesia; ineffective or dangerous medications or products; suspected abuse, neglect or exploitation of children, disabled adults or the elderly; or domestic violence);
- For federal or state government health-care oversight activities (e.g., civil rights laws, fraud and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.);
- For judicial and administrative proceedings and law enforcement purposes
- For workers' compensation purposes
- For intelligence, counterintelligence or other national security
- For organ and tissue donation
- For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality
- To create a collection of information that is "de-identified" (e.g., it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you);
- To family members, friends and others, but only if you verbally give permission; we give you an opportunity to object and you do not; we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (e.g., you bring someone with you into the operatory or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (e.g., to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (e.g., your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person.

Minimum Necessary Rule Our staff will not use or access your PHI unless it is necessary to do their jobs. Also, we disclose to others outside our staff only as much of your PHI as is necessary to accomplish the recipient's lawful purposes. For example, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and any one else you list on a Consent or Authorization
- To health-care providers for treatment purposes
- To the U.S. Department of Health and Human Services (e.g., in connection with a HIPAA complaint);
- To others as required under federal or Florida law;
- To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA

In accordance with the law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requester's purpose. Our privacy officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, the Plan's Privacy Officer will make a minimum necessary determination based on, but not limited to, the following:

- The amount of information being disclosed;
- The number of individuals or entities to whom the information is being disclosed;
- The importance of the use or disclosure;
- The likelihood of further disclosure;
- Whether the same result could be achieved with de-identified information;
- The technology available to protect confidentiality of the information; and
- The cost to implement administrative, technical and security procedures to protect confidentiality.

If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requester to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it. We allow access to areas where PHI is stored or filed only when we are present to supervise and prevent unauthorized access.

Business Associate Rule Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure.

Super-confidential Information Rule If we have PHI about you regarding HIV testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Health-care Treatment, Payment and Operations Rules (see above) without you first signing and properly completing our Consent form. If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special Rules (e.g., we are required by law to disclose it). If we disclose super-confidential information we will comply with state and federal law that requires us to warn the recipient in writing that re-disclosure is prohibited.

Changes to Privacy Policies Rule We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e., to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office.

Authorization Rule We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on a specifically worded, written Authorization form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it on our Authorization form, which is separate from any Consent or Acknowledgment we may have obtained from you. We will not condition treatment on whether you sign the Authorization (or not).

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

To Inspect and Copy You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our privacy officer on our Request to Inspect, Copy or Summarize form. Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if our privacy officer is present at all times. You may ask us to give you the copies in a format other than or ask us to prepare a summary in lieu of the copies. We may charge you a fee not to exceed Florida law to recover our costs (including postage, supplies and staff time as applicable), to duplicate or summarize your PHI. We will not condition release of the copies or summary on payment of your outstanding balance for professional services (if you have one), but we may condition release of the copies or summary on payment of the copying fees. We will respond to requests in a timely manner, without delay for legal review, in less than thirty days if submitted in writing on our form or otherwise, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (e.g., we do not have the PHI, it came from a confidential source, etc). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed health-care professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed health-care professional who is not affiliated with us, we will ensure a Business Associate agreement is executed that prevents re-disclosure of your PHI without your consent by the outside professional.

To Request Amendment / Correction If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a Request for Amendment / Correction form to our privacy officer. We normally will act on your request within 60 days from receipt, but we may extend our response time (within the 60-day period) no more than once and by no more than 30 days, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (e.g., it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in writing within 5 business days) tell you: why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosures of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

To an Accounting of Disclosures You may ask us for a list of those who got your PHI from us by submitting a Request for Accounting of Disclosures form to us. The list will not cover some disclosures (e.g. PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (e.g., paper or electronically) and the time period you want us to cover, which may be up to but no more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written Request for Restrictions on Use / Disclosure form to us (e.g., you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations.

To Request Alternative Communications You may ask us to communicate with you in a different way or at a different place by submitting a written Request for Alternative Communication form to us. We will not ask you why and we will accommodate all reasonable requests (including, e.g., to send appointment reminders in closed envelopes rather than by postcards, to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payments to us will be made if we communicate with you as you request.

To Complain or Get More Information We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (e.g., you disagree with a decision of ours about inspection / copying, amendment / correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We never will penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(877) 696-6775 (toll free)

Questions or Complaints?? --- Contact our **Privacy Officer**

Nancy DeGarmo • 6825 No. U.S. Hwy. #1 • Cocoa, FL. 32927-5012 • Nancy@AdvancedDental-PSJ.com

These privacy practices will be effective April 14, 2003, and will remain in effect until we replace them as specified above.