SMILEOLOGY™
IMPLANT, COSMETIC & FAMILY DENTISTRY
FACIAL ESTHETICS
Bluewater Bay | Miramar Beach | Santa Rosa Beach

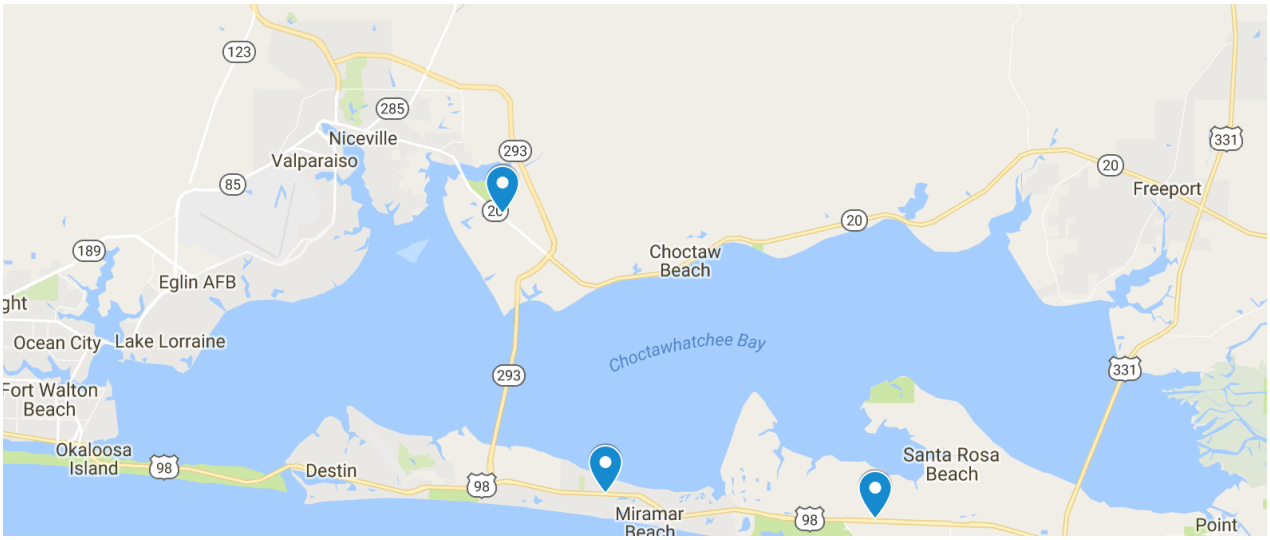
Thank you for choosing Smileology for your implant, cosmetic and family dentistry needs!

By choosing us, you have selected a practice whose doctors have demonstrated the high level of clinical experience that you should expect from your dental provider. Our doctors have over 50 years combined experience and have been practicing in the community for over 20 years.

Your appointment time is reserved especially for you. If you are unable to keep your appointment, please call us promptly so we may find a more convenient time for you. Thank you for your consideration.

Many thanks,

Your Smileology Team



Our three convenient locations

Bluewater Bay
4400 E Hwy 20 Suite 101 Niceville, FL 32578
850-897-4488

Santa Rosa Beach
4942 Hwy 98 Santa Rosa Beach, FL 32459
850-267-0777

Miramar Beach
12273 US Hwy 98 Suite 117 Miramar Beach, FL 32550
850-424-7887

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PATIENT INFORMATION

Title _____ Name _____ Gender _____ DOB _____

I prefer to be called _____ Marital status _____

Home address _____ City/State _____ Zip _____

Email address _____ Cell _____ Home _____

How did you hear about us? _____

DENTAL INSURANCE INFORMATION

Policy holder name _____ Policy holder DOB _____

Policy holder employer _____ Policy holder SSN _____

Dental insurance company _____ GROUP# _____

I understand Smileology is not contracted with any insurance plan and I am responsible for payment of all services rendered. I further understand that Smileology will file my dental claim once I have provided them with my current, correct dental insurance information. Returned checks will be charged $35.

Payment is due in full at time of treatment unless prior arrangements have been made.

Signature _____ Date _____

RELEASE OF MEDICAL INFORMATION

Please list anyone we may release your dental records/financial information to including appointments, treatment, etc. By signing this consent, information will be given to requesting providers without further signed authorization.

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Signature _____ Date _____

CONSENT FOR USE OR DISCLOSURE OF PATIENT PHOTOGRAPH AND/OR VIDEO IMAGES

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes. I understand that information disclosed pursuant to this authorization may be subject to disclosure and may no longer be protected by HIPAA privacy regulations. I understand I may revoke this authorization at any time, but such revocation must be in writing and received via registered mail. Revocation affects disclosure moving forward and not retroactive.

Signature _____ Date _____

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MEDICAL HISTORY

Are you under a physician's care now?	☐ Yes	☐ No	If yes:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes:
Have you ever had a serious neck injury?	☐ Yes	☐ No	If yes:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes:
Have you ever taken Fosamax or any other bisphosphonate?	☐ Yes	☐ No	If yes:
Do you use tobacco?	☐ Yes	☐ No	If yes:

Women: Are you… ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you taking any medications, pills, or drugs? Please list:

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa drugs ☐ Local anestheics
☐ Other? Please list:

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

☐ Abnormal bleeding	☐ Emphysema	☐ Herpes/fever blisters	☐ Radiation
☐ Alcohol/drug abuse	☐ Epilepsy	☐ High blood pressure	☐ Rheumatic Fever
☐ Anemia	☐ Fainting spells	☐ HIV+/AIDS	☐ Seizures
☐ Arthritis	☐ Frequent headaches	☐ Kidney problems	☐ Shingles
☐ Artificial bones/joints	☐ Glaucoma	☐ Liver disease	☐ Sickle Cell Disease
☐ Asthma	☐ Hay fever	☐ Low blood pressure	☐ Sinus problems
☐ Blood transfusion	☐ Heart attack	☐ Lupus	☐ Stroke
☐ Cancer/chemotherapy	☐ Heart murmur	☐ Mitral Valve Prolapse	☐ Thyroid problems
☐ Colitis	☐ Heart surgery	☐ Osteoporosis/Paget's	☐ Tuberculosis
☐ Congenital heart defect	☐ Hemophilia	☐ Pacemaker	☐ Ulcers
☐ Diabetes	☐ Hepatitis	☐ Psychiatric problems	☐ Venereal disease
☐ Difficulty breathing			

Please list any serious illness not listed above:

I understand that the information I have given today is correct to the best of my knowledge. I also understand it is my responsibility to inform his office of any changes in my medical status. I authorize the dental staff to perform any necessary services that I may need during diagnosis and treatment with my informed written consent.

Signature _____ Date _____

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DENTAL HISTORY

Patient Name _____

Please check any of the following problems that apply to you:

- ☐ Sensitivity/pain
  If so, where? UR UL LR LL
- ☐ Headaches, earaches, neck pain
- ☐ Joint pain, clicking/popping of jaw
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or painful gums
- ☐ Loose, tipped or shifting teeth
- ☐ Snoring/sleep apnea
- ☐ Bad breath

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

- ☐ Botox/dermal fillers
- ☐ Night guard
- ☐ Braces
- ☐ Deep cleaning/gum treatments
- ☐ Dentures/partials
- ☐ Sleep appliance

Name of previous dentist: _____

Phone number: _____

Date of last dental visit: _____

On a scale of 1-10, rate your current dental health: _____

Do you feel nervous about having dental care?
☐ Yes ☐ No

Do you smoke or use chewing tobacco?
☐ Yes ☐ No

Have your parents experienced gum disease/tooth loss? ☐ Yes ☐ No

I would like to discuss the following:

- ☐ A whiter smile
- ☐ A straighter smile
- ☐ Closing spaces
- ☐ Replacing metal fillings
- ☐ Repairing chipped teeth
- ☐ Replacing old crowns that don't match
- ☐ Gum recession
- ☐ Having a smile makeover

What is the most important thing to you about your dental visit today?

Why did you leave your previous dentist?

Have you had a bad past dental experience?

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____

SECTION B: TO THE PATIENT—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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether 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, and of other important matters about 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:

Contact Person: Melissa Garza

Telephone: (850) 897-4488 **Fax:** (850) 897-1446
Address: 4400 Hwy 20 East, Suite 101 Niceville, FL 32578
12273 US Hwy 98, Suite 117 Miramar Beach, FL 32550
4942 US Hwy 98, Suite 19 Santa Rosa Beach, FL 32459

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE SECTION: Please print your name on the top line and give your signature and date where indicated.

I, _____, have had full opportunity to read and consider the contents of this Consent form 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 activities and heath care operations.

SIGNATURE: _____ **DATE:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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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 04/14/2003 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 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 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 us using the information listed 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 a physician or other healthcare provider providing treatment to you.

Payment: We may use and 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 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 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.

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 for your healthcare, but only if you agree that we may do so.

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

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 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 at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a flat fee of $5.00 for copying your health information, records and x-rays, plus postage if you want the copies mailed to you.

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.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, 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 at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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.

Contact Officer: Melissa Garza

Telephone: (850) 897-4488 **Fax:** (850) 897-1446

Address: 4400 Hwy. 20 East, Suite 101, Niceville, FL 32578
12273 US Hwy 98 Suite 117 Miramar Beach, FL 32550
4942 US Hwy 98 Suite 19 Santa Rosa Beach, FL 32459

A larger print version of this notice is available upon request.