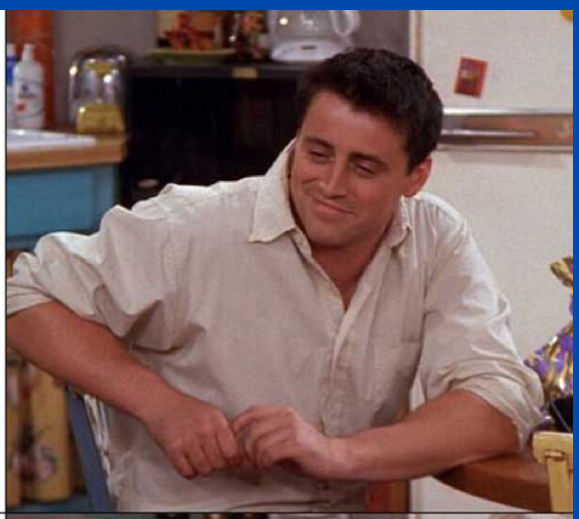
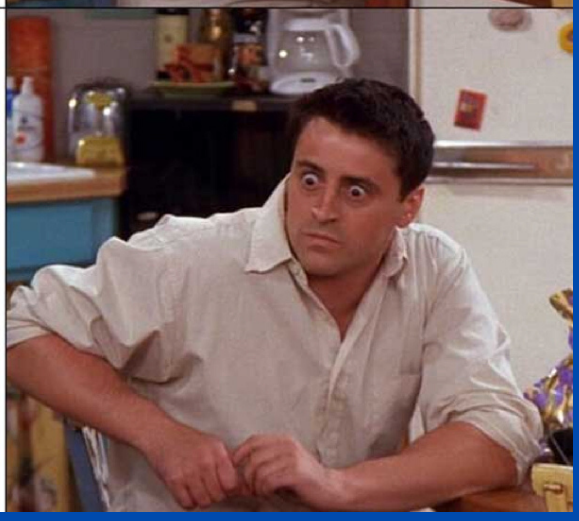
Lepore
COMPREHENSIVE DENTISTRY

New Patient Packet

Welcome to our practice. We have a few forms for you to fill out.



Are you kidding me?!



We recognize this paperwork is more extensive than you may be accustomed to. We have carefully curated these documents in order to provide you with outstanding care that goes above and beyond standard practice.

Thank you for taking the time to read through and complete this packet.

We look forward to meeting you soon!

THE MOUTH-BODY CONNECTION

Facts You Can't Ignore

Gum disease affects more than just your mouth.

Oral bacteria can travel to other parts of your body and have negative consequences.

80% **of American adults over 35** have some form of gum disease.

95% **of Americans with diabetes** also have periodontal disease.

If you have gum disease, you also are...

2x as likely to die from heart disease.

3x as likely to die from a stroke.

Sleep Apnea & Airway Obstruction

can increase your risk of high blood pressure and is also associated with diabetes, heart disease, and obesity.

If you have gum disease, you also have...

- risk of cancer including breast, pancreatic, lung, colorectal, esophageal, and oral cancers.
- risk of developing Alzheimer's disease.
- risk of premature birth and stillbirth when pregnant.

Bleeding Gums & Diabetes

increase your risk of premature death by

700%

https://www.aadsm.org/frequently_asked_questions_de.php
http://perio.org/consumer/gum-disease-and-other-diseases
https://www.colgate.com/en-us/oral-health/life-stages/oral-care-during-pregnancy/pregnancy-oral-health-and-your-baby
https://www.ncbi.nlm.nih.gov/pubmed/?term=pmc3004155
http://www.adha.org/sites/default/files/7228_Oral_Health_Total.pdf
https://www.ncbi.nlm.nih.gov/pubmed/?term=21933454
http://oralsystemiclink.net/home

SALIVARY TESTING

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WHAT'S IN MY MOUTH?

There are more than 700 different types of bacteria that live in our mouths. Scientists have discovered multiple strands of these bacteria cause biofilm, commonly known as plaque and tartar. This buildup sticks to our teeth and around the gumline and must be removed by a dental cleaning. Regular brushing and flossing help curtail the buildup as well. The longer plaque and tartar remain on your teeth, the greater the risk of harm to your health. Periodontal or "gum" pathogens are especially opportunistic during periods of emotional or physical stress. **These pathogens cause gingivitis and periodontitis (gum disease).**

THE MOUTH AND BODY CONNECTION

Multiple studies have linked harmful bacteria in the mouth not only to bad breath, cavities, and tooth loss but serious health issues including:

- Heart Attacks
- Stroke
- Cardiovascular Disease
- Diabetes
- Alzheimer's Disease & Dementia
- Some forms of Cancer (Pancreatic, Colon, Esophageal, Lung, Head & Neck)
- Premature birth or Miscarriage

HOW SALIVARY TESTING WORKS

The Salivary test is completely painless and simple. We collect a sample of your saliva by having you spit into a collection tube. Since your saliva contains bacterial DNA, the laboratory can analyze the sample to identify the harmful pathogens discussed above. Test results are available in about a week. Your results will be emailed to you along with a breakdown of your sample and any treatment recommendations that that are now uniquely indicated for you.

WHY IS SALIVARY TESTING IMPORTANT FOR ME?

Through salivary diagnostic testing, we can detect infection during its early stages, **even before it is recognizable through a visual exam**. The salivary test will allow us to determine if you are at increased risk for gum disease, heart attacks, strokes, dementia and more. This information allows us to offer customized treatment options to reduce the bacterial levels and ultimately decrease your risk for oral and systemic disease.

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COMPREHENSIVE DENTISTRY

Complete Health
Medical & Dental History Form

Although in Dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as the gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Therefore, it is important that you answer all of the pertinent questions. Thank you.

Patient Name: _____ Date:_____ Date of Birth: _____

Gender: [ ] Male [ ] Female [ ] N/A Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Social Security #_____ Driver's License #: _____ State: ___

Phone Numbers:
Home: _____ Work: _____ Cell: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Employer Name: _____

Employer Address: _____

If you are completing this form for another person, what is your relationship to that person?
Name: _____ Relationship to Patient: _____

Insurance Information:
Are you covered by dental insurance? [ ] Yes [ ] No
Subscriber Name: _____ Relation to Patient: _____
Subscriber Birth Date: _____
Address & Phone *(If different from patient):* _____
_____

Insurance Company & Address: _____
_____

Subscriber Employed by: _____ Business Phone: _____
ID # (listed on insurance card): _____

Building Relationships

We like to treat our patients like family and would like to get to know you as a person.

Occupation _____ Employer _____

Spouse/Partner's Name _____

Who lives at home with you? _____

How many children do you have (Please provide names, gender, and ages) _____

_____

_____

_____

Where were you born? _____ Where did you grow up? _____

Where do you live now and for how long? _____

Whom may we thank for referring you? _____

What would you like to know about our dental practice? _____

What would you like to know about our doctor? _____

Oral Health

Is there a specific dental problem that you currently have? _____

How many times per day do you brush your teeth? _____ What type of toothbrush do you use? _____

Do you floss regularly? [ ] Yes [ ] No How often? _____

How often do you see your dentist? _____ Do you ever have bleeding gums? [ ] Yes [ ] No

Does your oral health concern you? [ ] Yes [ ] No If yes, why? _____

Check (✓) if you have had problems with any of the following:

❒ Bad Breath
❒ Bleeding gums
❒ Grinding Teeth
❒ Sensitivity when biting
❒ Loose teeth or broken fillings
❒ Sensitivity to sweets
❒ Sensitivity to hot
❒ Sensitivity to cold
❒ Food collection between teeth
❒ Sores or growths in your mouth
❒ Clicking or popping jaw
❒ None

Check (✓) if you have been recommended any of the following by a dentist in the last 5 years:

❒ Deep Cleaning
❒ Root Canal
❒ Pulling A Tooth
❒ Bone Grafting
❒ Gum Grafting
❒ Cavity Filling
❒ Dental Crown
❒ Dental Bridge
❒ Dental Implant(s)
❒ Braces/Invisalign
❒ Nightguard
❒ Sleep Appliance/Snore Guard
❒ Complete/Partial Dentures
❒ Implant Dentures
❒ None

Lepore COMPREHENSIVE DENTISTRY

The Heart Attack & Stroke Prevention Center
Breaking ground with the Bale/Doneen Method

Bale Doneen METHOD

PARTNERS IN COMPLETE HEALTH

Would you be interested in (check all that apply):

Whiter Teeth [ ] Straighter Teeth [ ] Healthier Gums [ ] Fresher Breath [ ] Reducing snoring [ ]
Nicer Full Smile [ ] Keeping Your Natural Teeth for a Lifetime [ ] Quitting Smoking [ ] None [ ]

On a scale of 1-10, with 10 being your perfect smile, how would you rate your smile? Circle: 1 2 3 4 5 6 7 8 9 10

If you could wave a magic wand to take your smile to a 10/10, what would you change?

_____

_____

Personal Health

How would you rate your current health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Current age: _____ Weight:_____ Height: _____

Date of your last physical exam:_____ Date of last dental care/Former Dentist:_____

Reason for today's visit: _____

Medications: Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs.

Medications/ Supplements	*Dose (mg per pill, doses per day)*	*Start date*	*End date*

Allergies or Reactions to Medicines

Medications/ Supplements	*Reaction (Hives, Rash, Anaphylaxis)*	*Date of Initial Reaction*

Please list the Doctor(s) and/or Specialist(s) you see:

Doctor's Name	*Specialty*	*For What Condition(s) Do You See Them?*

Surgery/Hospitalization History

Please list all other operations and/or hospitalizations with the dates when they occurred.

Date	*For What Condition?*

Please indicate whether you have had any of the following medical problems: **(Include dates diagnosed)**

Dental:

Periodontal/Gum Disease ❒_____ Dental Infections/Abscess ❒_____

Root Canal Therapy ❒ _____ Bleeding Gums ❒ _____

TMJ/TMD ❒ _____

Cardiac:

Heart Attack ❒ _____ Stroke ❒ _____

High Blood Pressure ❒_____ Mini-Stroke or TIA ❒_____

High Cholesterol ❒ _____ Atrial Fibrillation ❒ _____

Heart Arrhythmia (Irregular Heartbeat) ❒ _____ Artificial Heart Valve ❒ _____

Congestive Heart Failure (CHF) ❒ _____ Pacemaker ❒ _____

Angina-Related Chest Discomfort ❒ _____ Aneurysm ❒ Brain ❒ Aortic ❒ _____

Bypass Surgery ❒ _____ Blood Clot in Legs [ ] _____

Mitral Valve Prolapse ❒ _____ Congenital Heart Disorder ❒ _____

Endocrine:

Pre-Diabetes ❒ _____ Thyroid Disease ❒ _____

Diabetes [ ] Type I ❒ Type II ❒ _____ Polycystic Ovaries ❒ _____

Low Testosterone ❒ _____ Osteoporosis ❒ _____

Hypoglycemia ❒ _____ Parathyroid Disease ❒ _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? [ ] Yes [ ] No

Autoimmune

Rheumatoid Arthritis ❒ _____ Lupus ❒ _____

Psoriasis ❒ _____ Sjögren's Syndrome ❒ _____

Crohn's Disease ❒ _____ Ulcerative Colitis ❒_____

Airway/Sleep:

Sleep Apnea ❒ _____ Insomnia ❒ _____

Restless Leg ❒_____ Asthma ❒_____

COPD/Emphysema ❒ _____ Sinus Issues ❒_____

Chronic Allergies ❒ _____ Tonsilitis ❒_____

Tonsils Removed ❒_____

Blood Disease:

Bleeding/Clotting Problems ❒ _____ Anemia ❒ _____

Abnormal Platelet Count ❒ _____ High Red Blood Cell Count ❒ _____

Low White Blood Cell Count ❒ _____ Blood Transfusions ❒ _____

Organ Systems

Intestinal Disease ❒ _____ Kidney Disease ❒ _____

Stomach Ulcers ❒ _____ Kidney Stones ❒ _____

Chronic Heartburn ❒ _____ Renal Dialysis ❒ _____

Stomach Ulcers ❒ _____ Gallbladder Stones ❒ _____

Hepatitis ❒ Type A ❒ Type B ❒ Type C ❒ _____ Gallbladder Removed ❒_____

Fatty Liver ❒ _____ Pancreatic Disease ❒ _____

Joints & Muscles

Artificial Joint ❒ L Knee ❒ _____ R Knee ❒ _____ L Hip ❒ _____ R Hip ❒_____ Other ❒ _____

Do You require premedication (antibiotics) prior to your dental visits ❒ Yes ❒ No ❒ Unsure

What is your premedication (name and dosage)?:_____

Please Note that is the responsibility of the cardiologist or orthopedic surgeon who requires this premedication to prescribe the antibiotic and not the treating dentist. Please contact your medical provider for refills.

Osteoarthritis ❒ _____ Fibromyalgia ❒ _____

Gout ❒ _____ Chronic Migraines ❒ _____

Lepore COMPREHENSIVE DENTISTRY

The Heart Attack & Stroke Prevention Center
Breaking ground with the Bale/Doneen Method

Bale Doneen METHOD

PARTNERS IN COMPLETE HEALTH

This form was developed by the Heart Attack & Stroke Prevention Center, the Bale/Doneen Method & Partners In Complete Health.

Cancer

❒ Type(s): _____ ❒ Current ❒ In remission

❒ History of Radiation ❒ History of Chemotherapy ❒ History of Resection (Surgical Removal) ❒ N/A

Mental Health

Alzheimer's Disease/Dementia ❒ _____ Mental Disability ❒ _____

Anxiety/Panic Attacks ❒ _____ Depression ❒ _____

Seizure Disorder ❒ _____ Suicide Attempts ❒ _____

Bacteria & Virus

Tuberculosis ❒ _____ HIV/AIDS ❒ _____

Human Papilloma Virus (HPV) ❒ _____ Herpes ❒ ❒ Simplex 1 ❒ Simplex 2 _____

COVID-19 ❒ _____ Shingles ❒ _____

Influenza (Flu) – Last 12mo ❒ _____ Venereal Disease ❒ _____

Epstein-Barr Virus (EBV) ❒ _____

Physical Disability

❒ Type(s): _____

What accommodations can we assist you with? _____

Other (Not Listed)

❒ _____ ❒ _____

❒ _____ ❒ _____

Family history

Please indicate with a check mark any family members who have had any of the following medical conditions:

Medical condition	Mom	Dad	Sister	Brother	Daughter	Son	Mom's mom	Mom's dad	Dad's mom	Dad's Dad	Mom's sister	Mom's brother	Dad's sister	Dad's brother
Gum Disease/Perio														
Bad Teeth														
Heart Attack														
Stroke														
Mini-Stroke (TIA)														
Coronary Stents														
Coronary Bypass														
Aortic Aneurysm														
High Blood Pressure														
Diabetes Type 2														
High Cholesterol														
Sleep Apnea														
Alzheimer's/Dementia														
Thyroid Disease														
Autoimmune Disorder														
Rheumatoid Arthritis														
Cancer – Pancreatic														
Cancer - Colon														
Cancer - Esophageal														
Cancer – Lung														
Cancer – Head/Neck														
Anxiety/Depression														
Polycystic Ovary Disease														
Early-Term Birth/Miscarriage														

Social History

Tobacco use

Cigarettes: [ ] Never [ ] Quit: Date you quit smoking _____ [ ] Current smoker (packs per day) _____
Other tobacco (check all answers that apply): [ ] Pipe [ ] Cigar [ ] Chewing tobacco [ ] e-cigarettes
Number of years you've used this tobacco for EACH _____
Are you interested in quitting? [ ] Yes [ ] No Have you tried to quit in the past [ ] Yes [ ] No
How many times have you tried to quit? _____ What methods have you tried? _____
Are you exposed to second-hand smoke? [ ] Yes [ ] No If yes, for how long? _____

Alcohol use

Do you drink alcohol? [ ] Yes [ ] No
If yes, how many drinks do you consume per week? _____ Alcohol type _____
Does your alcohol consumption have you or others concerned? [ ] Yes [ ] No
Have you been diagnosed with Alcoholism? [ ] Yes [ ] No

Drug use

Do you or have you ever used recreational drugs? [ ] Yes [ ] No
Types (check all that apply): [ ] Marijuana [ ] Cocaine [ ] Benzodiazepines [ ] Ecstasy/MDMA [ ] LSD [ ] Heroin
If yes, which are you currently using: _____
Are you interested in quitting? [ ] Yes [ ] No
Have you ever been admitted to an institution/clinic for drug abuse/use? [ ] Yes [ ] No

Stress

How would you classify your stress level at work? (Please check one) [ ] Low [ ] Medium [ ] High
How would you classify your stress level at home? [ ] Low [ ] Medium [ ] High
Do you often feel anxious, angry, irritated or rushed? [ ] Yes [ ] No

Sleep quality

Have you been told you snore? [ ] Yes [ ] No
Do you typically awaken refreshed or tired? [ ] Refreshed [ ] Tired Do you feel tired after lunch? [ ] Yes [ ] No
Do you have trouble falling asleep? [ ] Yes [ ] No Do you have trouble staying asleep [ ] Yes [ ] No
Do you awaken more than once a night to use the restroom? [ ] Yes [ ] No
Do you use medications or over-the-counter supplements to help you sleep? [ ] Yes [ ] No Which Ones? _____
Do you have difficulty breathing through your nose comfortably? [ ] Yes [ ] No
Do you suffer from morning headaches or migraines? [ ] Yes [ ] No
Has anyone seen you stop breathing while sleeping? [ ] Yes [ ] No
Has anyone caught you or have you caught yourself waking up gasping or choking? [ ] Yes [ ] No
Have you had a sleep study? [ ] Yes [ ] No Date_____
Have you ever been told to get a sleep study? [ ] Yes [ ] No
Have you been diagnosed with sleep apnea? [ ] Yes [ ] No

Do you wear a C-PAP? [ ] No [ ] Currently [ ] In The Past

Diet

Caffeine intake

Coffee _____ cups/day Tea_____ cups/day Sodas per day _____ [ ] Diet [ ] Regular

Chocolate _____ ounces per day (Circle one.) [ ] Dark [ ] Light

Do you drink energy drinks or take pills to stay awake? [ ] Yes [ ] No If yes, specify _____

Exercise

Do you exercise regularly? [ ] Yes [ ] No What kind of exercise? _____

How long do you exercise in minutes? _____ How often? _____

If you do not exercise, why not? _____

Do you have any limitations to your ability to exercise? Please explain _____

History for Women

How many times have you been pregnant? _____ How many deliveries? _____ miscarriages? _____

Please list any problems you have experienced with pregnancy or delivery: _____

_____

Pregnancy - early term birth? [ ] Yes [ ] No How many? _____

Do you have osteoporosis (bone loss)? [ ] Yes [ ] No osteopenia (bone thinning)? [ ] Yes [ ] No

Menopause? [ ] Yes [ ] No

Hysterectomy? [ ] Yes [ ] No When _____ Ovaries removed? [ ] Yes [ ] No

Do you have any history of gestational diabetes? [ ] Yes [ ] No

High blood pressure or eclampsia with pregnancy? [ ] Yes [ ] No

We sincerely thank you for taking the time to complete this medical-dental history. You may be asking yourselves what a lot of this has to do with a dental visit. The answer is: "Quite a bit!" We look forward to partnering with you to achieve the level of wellness you seek, both for your oral health and your overall health. Welcome to our practice!

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on08/01/2016 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, **Anissa Steiger.**
Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be **$ 0.00** for each page and the staff time charged will be **$0.00** per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be **$0.00** for each page and the staff time charged will be **$0.00** per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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. **HOW TO CONTACT US:**

Practice Name: **Lepore Comprehensive Dentistry** Privacy Officer: **Anissa Steiger**

Telephone: **727-733-4113** Fax: **727-733-4568**

Email: **Smile@LeporeDentistry.com**

Address: **822 Milwaukee Avenue, Dunedin, FL, 34698**

Lepore
COMPREHENSIVE DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

PERMISSION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you

Notice to Patient: By signing this form, you acknowledge that our practice may use and disclose PHI about you or treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Printed Name of Patient *Date*

_____

Signature of Patient or Legal Representative

_____

Legal Relationship to Patient (if required)

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s)of the individual(s) you authorize our office to discuss care with. **I give you permission to share my protected health information (PHI) with:**

1. Name:_____ Relationship:_____ Phone:_____

2. Name:_____ Relationship:_____ Phone:_____

3. Name:_____ Relationship:_____ Phone:_____

This form does not constitute legal advice and covers only federal, no state, law.

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COMPREHENSIVE DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

CONSENT TO EMAIL OR TEXT COMMUNICATION

Consent to email or text for appointment reminders and other healthcare communication

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is**:**

_____ _____

Cell Phone Number *Please Initial*

The email address I authorize to receive email messages for appointment reminders and general health information is:

_____ _____

Email Address *Please Initial*

- OR-

☐ **I decline** to receive communications via **text.**

☐ **I decline** to receive communications via **email.**

Revocation – Use this area to document revocation of a previous form of communication.

☐I hereby revoke my request to receive future appointment reminders or healthcare updates via **text.**

☐I hereby revoke my request to receive future appointment reminders or healthcare updates via **email.**

_____ _____

Patient (or Legal Guardian) Signature *Date Requested*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.

☐ We were not able to communicate with the patient.

☐ Other *(Please provide specific details)* _____

_____ _____

Employee Signature *Date*

This form does not constitute legal advice and covers only federal, no state, law.

Lepore
COMPREHENSIVE
DENTISTRY

RESERVED APPOINTMENT AGREEMENT

Dear Patient,

Appointment times in our office are reserved especially for you. This convenient appointment system helps our office run smoothly for both our patients and our team. We schedule an appropriate amount of time for your treatment, and we take pride in staying on schedule, preventing any unnecessary waiting time. We want you to know that we value and honor your time!

When making an appointment, please be sure that your other obligations allow you enough time to arrive promptly for your dental visit. Your cooperation allows us to be on time for your appointment and our other patients.

If you know that you will be arriving 5 or more minutes late, please call before you come. This way, if it becomes necessary to reschedule your appointment, you will have avoided a hurried trip to the office and made it possible for us to offer that time to a patient who is waiting on our VIP list.

If you find you are unable to keep your scheduled appointment, please call in advance so that we may reschedule you at a more convenient time. There will be no charge if we are notified at least 48 business hours before the scheduled appointment. Should you fail to contact us with less than 48 business hours notice:

1st Time: In certain circumstances, we will ***potentially*** waive the fee as a courtesy (We understand things happen!)

2nd Time and Thereafter:

- A missed/broken doctor (dental treatment) appointment **within 48 hours** will incur a fee of 25% of the value of the visit with a minimum of a $50 charge.
- A missed/broken hygiene (cleaning) appointment **within 48 hours** will incur a fee of 25% of the value of the visit up to $500 with a minimum of a $50 charge.

If you are a family of 2 or 3 scheduled for the same time and find that one of them is not able to attend, please try to keep the other appointments to avoid multiple charges for each of missed appointments.

Thank you for your cooperation, courtesy, and understanding.

Your complete health dental team,

Lepore Comprehensive Dentistry

_____	_____	_____
Print Name	Signature	Date

Lepore
COMPREHENSIVE DENTISTRY

FINANCIAL UNDERSTANDING

Thank you for choosing Lepore Comprehensive Dentistry as your healthcare dental provider.We are committed to successful treatment performed to the highest standard of care, so that you may fully attain optimum oral health throughout your life. In addition, we will strive to make your visit pleasant and comfortable. We have found that a clear agreement regarding financial policy before treatment begins results in a better doctor- patient relationship. Please understand that your bill is considered part of your treatment.

Payment Methods:

_____ *Please Initial*

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. We are happy to offer 3rd party financing through CareCredit and Wells Fargo Financing.

_____ *Please Initial*

Please Note: In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to $70.00.

Missed/Broken Appointments:

_____ *Please Initial*

A missed/broken hygiene (cleaning) appointment **within 48 hours** will incur a fee of 25% of the value of the visit up to $500 with a minimum of a $50 charge.*

_____ *Please Initial*

A missed/broken doctor (dental treatment) appointment **within 48 hours** will incur a fee of 25% of the value of the visit up with a minimum of a $50 charge.*

**It's important to note that any deposit made towards treatment may be put towards the broken appointment fee and will be non-refundable.*

Deposits

_____ *Please Initial*

To secure an appointment that is valued at $500.00 or more, or exceeds two hours of provider time, a minimum of a 25% deposit will be collected **at the time of booking**. Please note that this deposit is non-refundable and will be applied towards the final cost of the visit. Should the patient cancel within 48 hours, the deposit will be forfeited.

CONSENT:

I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, re-billing, collection charge or attorney feewill be added to any overdue balance. I also assign all insurance benefits to the Doctor.

_____ _____

Printed Patient Name *Date*

_____ _____

Patient (Guardian/Representative) Signature *If Guardian/Representative, Print Name and Relationship to Patient*

Lepore
COMPREHENSIVE DENTISTRY

INSURANCE UNDERSTANDING

_____ *Please Initial*

As a courtesy to you, we will help you process all your insurance claims. Please understand that we provide an insurance estimate to you, however it is ***not a guarantee*** that your insurance will pay exactly what is estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course do all we can to make sure your estimate is as accurate as possible.

_____ *Please Initial*

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, or with the patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

_____ *Please Initial*

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment ***regardless of any insurance company's arbitrary determination of usual and customary rates.***

_____ *Please Initial*

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to you.

_____ *Please Initial*

At the time of service, we ask that you pay the fee for the associated procedures by cash, check, American Express, MasterCard, Visa, or Discover. We will then submit a courtesy claim on your behalf and instruct the insurance company to issue a check to you.

_____ *Please Initial*

Insurance Payments are ordinarily received within 30-45 days from time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. **If payment is not received or your claim is denied**, please contact our office as soon as possible as we may be able to assist you in further processing the claim.

_____ *Please Initial*

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. ***Our office will not, however, enter into a dispute with your insurance company over any claim in perpetuity.*** Please contact our office as soon as possible as we may be able to further assist you in processing the claim.

_____ *Please Initial*

If you do not wish to have our assistance with your insurance claims, you may choose to pay at the time of service and submit the insurance claim yourself. Please speak to our office manager if this is your desire.

_____ *Please Initial*

Please understand that insurance is a method of payment, not a method of treatment. While we certainly take your insurance benefits into consideration while formulating a treatment plan, we do not allow ourselves to treatment plan based solely on what your insurance may or may not cover. The need for treatment is diagnosed by doctor irrespective to insurance coverage.

_____ *Please Initial*

Please note that we cannot file a claim to your insurance company if you have an In-Office Dental Savings Plan. In the event that a patient has a dental insurance plan and chooses to purchase the dental savings plan, we would then only estimate fees and use the Dental Savings Plan and remove the dental insurance plan from the patient's file.

We thank you for the opportunity to serve your dental health needs and welcome any questions you may have concerning your care or our financial policy.

_____ _____
Printed Patient Name *Date*

_____ _____
Patient (Guardian/Representative) Signature *If Guardian/Representative, Print Name and Relationship to Patient*

Lepore
COMPREHENSIVE
DENTISTRY

Authorization For the Taking Photographs/Videos for Diagnostic Purposes

Photographs and Videos are an important part of the examination process and are essential when developing a diagnosis and appropriate treatment options. When the doctor evaluates your records after the examination, it is important to have photographic documentation in addition to X-rays, to make a complete and proper diagnosis. The photographs, and to a lesser extent videos, are also essential when communicating with any other health care professionals.

In connection with dental services which I, _____, am receiving from Lepore
Printed Patient Name

Comprehensive Dentistry, I authorize that photography and videography may be taken of me, such as my face, jaws, and teeth under the following conditions:

1. The photographs may be taken only with the consent of the attending doctor.

2. The photographs shall be used for dental/medical records.

3. Photographs and videos shall be taken for the purposes of diagnosing dental conditions, planning treatment, documentation, and *your* education about your dental condition. Within your electronic health record, dental photographs/videos illustrate the following - how the structures and landmarks of the face frame a person's smile; the presence or absence of oral/dental disease; how a person's teeth come together to form their bite; the anatomy of a person's mouth, jaws, and teeth; before and after treatment comparisons; the progression of disease and the return to health from a state of disease.

_____
Please Initial

Please initial to indicate that you understand that Lepore Comprehensive Dentistry will take photographs/videos of you for diagnostic purposes, understanding that these visual materials will solely be used to aid your dental treatment and will be handled with utmost privacy and confidentiality.

I fully understand and accept the terms of this authorization.

_____ _____
Printed Patient Name *Date*

_____ _____
Patient (Guardian/Representative) Signature *If Guardian/Representative, Print Name and Relationship to Patient*

Witness

_____ _____
Witness Signature *Date*

Lepore
COMPREHENSIVE DENTISTRY

Authorization For the Publication of Photographs/Videos

I _____, give authorization to Lepore Comprehensive Dentistry to publish photographs and
Printed Patient Name
videos of myself on their website, and/or social media platforms for the purpose of promoting the services provided by our providers. I understand that these photographs and videos may be used in marketing material, blog posts, social media posts, and other online or offline promotional Materials.

I acknowledge that the photographs and videos may include profile photos and close-ups of my mouth during the dental treatment. I understand that my identity will be protected, and my name will not be disclosed when these materials are published.

I also understand that I have the right to revoke this authorization at any time by providing a written notice to Lepore Comprehensive Dentistry. However, I acknowledge that revoking these authorizations will not affect any materials that have already been Published or distributed.

By signing below, I confirm that I have read this consent form, understand its contents, and freely and voluntarily authorize the publication of photographs and videos as described above.

_____ I do not expect compensation, financial or otherwise, for the use of these photographs/videos.
Please Initial

Please indicate if you ***would allow*** your photos/videos to be used for any marketing and/or social media (Website, Facebook, Instagram, YouTube, Twitter, Pinterest, Blog) purposes (for example: before and after shots, testimonials)..

Yes No

Please indicate if you allow publication of **photographs not showing the face** but instead close-ups of the mouth and teeth showcasing the treatment provided with no identifying information.

Yes No