Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you to help in maintaining your dental health.

Patient Information

Patient Name _____ Birthdate _____ Phone # _____

Address _____ City _____ State ___ Zip _____

Parent or guardian if patient is a child _____

Occupation_____ Social Security # _____

Name of employer _____ Phone # _____ Driver License# _____

Person financially responsible for this account _____

Whom may we thank for referring you? _____

Dental History

Reason for today's visit_____

When was your last visit to the dentist? _____ What was done? _____

Have you ever had a tooth removed? _____ If so, any complications or excessive bleeding? _____

Are your teeth sensitive to heat _____ cold_____ or sweets?_____

How often do you brush your teeth? _____

Do you use dental floss regularly? _____

Do you use a mouthwash? _____ If so, which one? _____

Please complete both sides

Do your gums bleed? _____ Have you ever had gum treatment? _____

Do you grind or clench your teeth? _____ Any pain in or around your ears? _____

How do you feel about your smile? _____

Are you interested in cosmetic dentistry? _____

Health History

Physician's Name _____ Phone # _____

What is your general state of health? Excellent_____ Good_____ Fair _____ Poor_____

Are you now under the care of a physician?_____ For what condition? _____

Have you had a major illness, operation or been in a hospital? _____ Explain_____

Have you had a reaction to a local or general anesthetic? _____

Are you allergic to any medication? _____ If so, which one_____

Have you had hepatitis, jaundice or any other liver disease? _____

Do you have AIDS or tested positive for HIV antibody? _____

Do you have a heart murmur or any other heart problems? _____

Do you have high blood pressure? _____ Is it controlled? _____

Do you have diabetes? _____ Do you have arthritis? _____

(Women) Are you pregnant? _____ Are you taking birth control pills? _____

Additional comments _____

_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Singnature _____ Date _____

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required 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 04/14/03, 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0. 1.00 for each page, $ 10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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: _____

Telephone: 305 5566055 Fax: 305 5566440

E-mail: _____

Address: 4999 W 8 ave #28
Hialeah, Fl 33012

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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)

_____

_____

_____

Susana Lizaso, D.D.S.

4999 West 8th Avenue Suite 28
Hialeah, FL 33012

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGE

Please print (Last name) (First Name) (Mi)

Do we have permission to:

Send a yearly appointment card to your home? Y_____ N_____

Send tests results to your home? Y_____ N_____

Leave the following information on your home answering machine/voice mail:

Appointment information Y_____ N_____

Billing information Y_____ N_____

Medical information Y_____ N_____

Leave the following information on your work answering machine/voicemail:

Appointment information Y_____ N_____

Billing information Y_____ N_____

Medical information Y_____ N_____

I give permission to share appointment information with the person named below:

Name_____

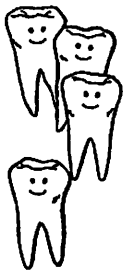
I give permission to share medical information including biopsy and lab results with the person listed below:

Name_____

I give permission to share billing information with the person listed below

Name_____

Signature of Patient:_____ Date:_____



Susana Lizaso, D.D.S.

4999 West 8th Avenue Suite 28
Hialeah, FL 33012

CONSENT TO TAKING AND PUBLISHING PHOTOGRAPHS

Patient: _____

Date: _____

In connection with the dental services which I am receiving from my dentist, Dr.Susana Lizaso, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my dentist and under such conditions and at such times as may be approved by her.

2. The photographs may be taken by my dentist or by a photographer approved by my dentist.

3. The photographs shall be used for dental records and if in the judgment of my dentist, dental research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which she may deem proper in the interest of dental education, knowledge, or research; provided, however, that it is specially understood that in any such publication or use I shall not be identified by name.

4. The aforementioned photographs may be modified or retouched in any way that my dentist, at her discretion, may consider desirable.

Signed:_____

Witness:_____

Date:_____

Insurance Authorization Form

Susana Lizaso D.D.S
4999 West 8 ave, suite #18
Hialeah, Fl 33012
(305)556-6055

SIGNATURE ON FILE

By signing this paper, I_____

- Authorize use of this form on all my insurance submissions.
- Authorize release of information to all my insurance carriers.
- Understand that I am responsible for my bill.
- Authorize payment directly to my doctor.
- Permit a copy of this authorization to be used in place of the original.

Name_____
Please print

Signature_____ Date_____