PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Dr. Llano's office at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do not agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

CHARLES D. LLANO, D.D.S., P.A. NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Charles D. Llano, D.D.S., P.A. we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Tracy Warner, at (863)644-2428.

This notice goes into effect as of April 14, 2003.

Acknowledgment

I have received a copy of Charles D. Llano, D.D.S., P.A. Notice of Privacy Practices. Date_____

Signed_____ Print Name_____

If signing as a parent or guardian, please note the name of the patient_____

Personal Dental Needs Survey

Name:_____ Date:_____

1. Please rate in order of importance, your primary concerns regarding your dental care. (The most important would be #1).

____ Preventive Dental Health Care
____ Excellence and Quality of Service
____ Cost and affordability
____ Freedom of pain
____ Other

2. Please rate, as in question #1, what a dentist has to do to gain your confidence.

____ Show me what he is doing or needs to do in a way that I can understand.
____ Listen to my concerns
____ Make sure I feel comfortable and informed at all times.

3. Please circle the level of fear you have about your dental visits. (10 being the greatest)
   1 2 3 4 5 6 7 8 9 10

4. Are you concerned about the following: (yes or no)

____ Existing discomfort?
____ Replacing old silver fillings?
____ Reoccurring or untreated gum disease?
____ Mouth odor
____ Prevention of decay?
____ Oral Cancer?
____ Whitening your teeth
____ Other:

5. When evaluating my smile. It is more important: (circle one)

   What others see What I see

6. Do you like your smile? Yes or No
   If not what would you like to change?

7. If you did not have dental insurance, would you still have dental care completed?
   Yes or No

8. When discussing my treatment plan, I prefer:
   THE BIG PICTURE DETAIL BY DETAIL

Charles Llano D.D.S., P.A.

General Dentistry
Restorative Care
Esthetic Services

Member
American Dental Association
Florida Dental Association
Polk County Dental Association
American Dental Society
of Anesthesiology

Fellow
American College of Dentists
Academy of General Dentistry

AGREEMENT TO CARE FOR CHILDREN

Dental treatment for children is necessary to stop damage that can become lasting and serious. As parents we know dental care is important and we know young people will not always understand why.

As a Dentist and a parent, I want treatment to be efficient and effective. Fears and concerns expressed by crying and behavior that hurts the outcome of care must be discussed openly before treatment begins. It is much easier when both the parents and the dentist have made good working rules.

- I will begin with an examination followed by a discussion of any findings. At this time, parents need to mention any concerns or facts that may affect treatment. Combined ideas will determine the best course of care.
- When needed, a medication or drug for sedation will be administered only with parental consent and counsel. The use of these types of drugs will be agreed on before the appointment.
- You will be asked to remain in the reception area while your child is cared for. For things to work, I must focus on a very special person- the patient.
- On completion of the appointment, I can discuss what was done. This is also a good time to prepare for the next visit.

Impressions and feelings are formed very early in life. With the correct care, the worry of "simply awful" can become a reality of "awfully simple."

320 West Highland Drive • Lakeland, FL 33813 • 863-644-2428 • Fax: 863-644-6235 • dentaldate@aol.com

X-RAY RELEASE REQUEST

Please forward x-rays requested to:

CHARLES D. LLANO, D.D.S.
320 W. HIGHLAND DR.
LAKELAND, FL 33813

Email address: lakelanddds@gmail.com

PATIENT:_____

X-RAYS REQUESTED_____

PATIENT SIGNATURE_____

CHARLES LLANO, D.D.S.

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1. PATIENT INFORMATION

DATE			
NAME OF PATIENT			
GUARDIAN (if Patient is your child)			
ADDRESS			
CITY		STATE	ZIP
HOME #	CELL #	EMAIL:	
HOW DO YOU PREFER TO BE CONTACTED? HOME or CELL or EMAIL (please circle one)			
BIRTHDATE		AGE	
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NUMBER			

DENTAL INSURANCE INFORMATION

EMPLOYER	EMPLOYEE
INSURANCE CARRIER	GROUP #
EMPLOYEE SS#	DOB
EMPLOYEE ID #	

2. GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? YES or NO (please circle one) If Yes, THEIR NAME
REFERRED TO US BY
PERSON TO CONTACT FOR EMERGENCY NAME
PHONE NUMBER
ADDRESS
CITY STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU NAME
PHONE NUMBER
ADDRESS
CITY STATE ZIP

3. PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

YOUR:
NAME
OCCUPATION
EMPLOYER
BUSINESS TELEPHONE EXT.
YOUR SPOUSE:
NAME
OCCUPATION
EMPLOYER
BUSINESS TELEPHONE EXT.

PATIENT HEALTH HISTORY

CIRCLE ONE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment or ever had a bad experience? ..... YES NO
3. Have you been a patient in the hospital during the past two years? ..... YES NO
4. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name _____

   Address _____ Phone # _____

5. Have you taken any medicine or drugs in the last two years? ..... YES NO
6. Do you take any medicine to improve bone density (Bisphosphotantes) Examples: Fosamax, Actonel, Boniva ..... YES NO
7. Do you regularly or occasionally use Tobacco products? ..... YES NO
8. Are you now taking any medicine, drugs, or pills? ..... YES NO

   If yes, please list _____

9. Are you allergic or have you reacted adversely to any of the following:

Aspirin	Erythromycin	Demarol
Darvon	Tetracycline	Valium
Codeine	Penicillin	Sleeping Pills (Nembutail / Seconal)
Percodan	Other Antibiotics	Dental Anesthetics (Local)

10. Are you aware of being allergic to any other medications or substance? ..... YES NO

    If yes, please list _____

11. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	Ulcers	A.I.D.S.
Heart Disease or Attack	Cough	Pain in Jaw Joints	Hepatitis A (Infectious), B (Serum)
Angina Pectoris	Tuberculosis (TB)	Sickle Cell Disease	Liver Disease
High Blood Pressure	Asthma	Yellow Jaundice	Kidney Trouble
Heart Mumur / Mitral Valve Prolapse	Hay Fever	Blood Transfusion	Glaucoma
Rheumatic Fever	Sinus Trouble	Drug Addiction	Psychiatric Treatment
Congenital Heart Lesions	Allergies or Hives	Hemophillia	Bruise Easily
Scarlet Fever	Diabetes	STD	Cosmetic Surgery
Artificial Heart Valve	Thyroid Disease	Cold Sores	
Heart Pacemaker	X-ray Cobalt Treatment	Fever Blisters	
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Epilepsy or Seizures	
Artificial Joints (Hip, Knee)	Arthritis	Fainting or Dizzy Spells	
Anemia	Rheumatism	Nervousness	

12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
13. Do your ankles swell during the day? ..... YES NO
14. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
15. Do you ever wake up from sleep short of breath? ..... YES NO
16. Are you on a special diet? ..... YES NO
17. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
18. Do you have any disease, condition, or problem not listed? ..... YES NO

Women, are you pregnant? YES NO If yes, due date? _____ Are you taking birth control pills? YES NO

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that 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 agreements have been made. I further understand that 1-1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default. I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____