Erik Z. Zudans, D.M.D., P.A.

725 N. A1A Suite D107 Jupiter, FL 33477

Phone: (561) 746-7436

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE

NAME (Last) (First) (Middle) | HOME PHONE | BUSINESS PHONE/ CELL PHONE

STREET ADDRESS (Include APT No) | CITY | STATE | ZIP CODE

DATE OF BIRTH | SEX | WEIGHT | HEIGHT | MARITAL STATUS | OCCUPATION

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? | PERSON TO CONTACT IN CASE OF EMERGENCY | PHONE

FINANCIAL INFORMATION

Who is responsible for your account?

Do you prefer to pay for services by: ☐ Cash ☐ Credit Card ☐ Check

INSURANCE ADDRESS | PHONE

CITY | STATE | ZIP CODE

Do you have Dental Insurance? ☐ **Yes** ☐ **No**

NAME OF INSURED | DOB OF INSURED

PRIMARY INSURANCE CARRIER | INSURED'S SOCIAL SECURITY NUMBER | INSURED'S EMPLOYER

HEALTH HISTORY

1. Are you in good health?
2. Has there been any change in your general health within the past year?
3. My last physical examination was on _____
4. Are you now under the care of a physician?
   If so, what is the condition being treated? _____
5. My physician's name is _____ Phone _____
6. Have you been hospitalized or had a serious illness within the past 5 years?
7. Please list all **medication, drugs, or pills** you take

8. Are you **ALLERGIC**, or have you reacted adversely, to any of the following medications: (Please circle)

Aspirin	Demerol	Valium	Penicillin	Sulfa Drugs	Dust
Darvon	Percodan	Sleeping pills	Erythromycin	Local Anesthetic	Materials
Codeine	Scopolamine	Nitrous Oxide	Tetracycline	(Novacaine or Xylocaine)	(Latex, Metals)

List additional **ALLERGIES**:

9. Have you ever had or do you have: (Please check if yes)

☐ Heart Trouble	☐ A Stroke	☐ Kidney Disease	☐ Hepatitis (liver disease)
☐ Heart Attack	☐ Bleeding Problems	☐ Glaucoma	☐ Diabetes (sugar in blood)
☐ Heart Murmur	☐ Tumor or Growth	☐ Tuberculosis	☐ Anemia
☐ Mitral Valve Prolapse	☐ Cancer Radiation	☐ Ulcers	☐ Convulsions (Epilepsy)
☐ High Blood Pressure	☐ Arthritis	☐ Blood Transfusions	☐ Venereal Disease
☐ Rheumatic Fever	☐ Asthma	☐ Shortness of Breath	☐ AIDS

PLEASE TURN OVER AND COMPLETE OTHER SIDE

HEALTH HISTORY (continued)

11. Are you HIV positive? ☐ Yes ☐ No
12. Are you subject to prolonged bleeding? ☐ Yes ☐ No
13. Has anyone in your family had diabetes? ☐ Yes ☐ No
14. Have you ever taken Anti-depressant medication? ☐ Yes ☐ No
15. Do you smoke? (If yes, how much) _____ ☐ Yes ☐ No
16. Do you consume alcohol? (If yes, how much per day) _____ ☐ Yes ☐ No
17. Do you have any disease, condition, or problem, not listed above that you think we should know about? (If yes, explain) _____ ☐ Yes ☐ No
18. Do you wish to talk to the doctor privately about any problem? ☐ Yes ☐ No

FOR WOMEN ONLY

1. Are you Pregnant? (If yes, what month) _____ ☐ Yes ☐ No
2. Are you taking birth control pills? ☐ Yes ☐ No

Please use this space to add any additional health information

DENTAL HEALTH HISTORY

My Concerns and reason for today's visit:

Date of last dental exam: Month ____ / Year ____

1. Are you satisfied with the appearance of your teeth?
2. Do you have any pain in your teeth because of heat, cold, or sweets?
   If so, where?
3. Do you have any pain in any part of the mouth or in any tooth while biting or chewing?
   If so, where?
4. Do your gums bleed, either in chewing or brushing or at any other time?
   if so, when?
5. Do you have any concerns about bad breath?
6. Do you clench your teeth during the day or have you been made aware of clenching your teeth during the night?
7. Do you want to keep your own teeth as long as possible?
8. How important are your teeth to you?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Zudans, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

CONSENT

The undersigned hereby authorizes Dr. Zudans to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Zudans, to make a thorough diagnosis of the patient's dental needs (which may be used in presentations or publications given by him). I also authorize Dr. Zudans to perform any and all forms of treatment, and prescribe medication or therapy, that may be indicated in connection with this patient. I further authorize and consent for Dr. Zudans to choose and employ such assistance as he deems fit. I authorize Dr. Zudans to keep my signature on file to submit dental insurance claims on my behalf.

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 dependants is mine, due and payable at the time services are rendered. All Lab Services must be paid for in full or have written financial arrangements prior to final delivery.

Signature _____ Date _____ Relationship to patient _____

Erik Z. Zudans DMD, PA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Erik Z. Zudans DMD, PA this ___ day of _____, 20__. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Please print your name

_____
Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority _____.

Thank you and if you have any questions about this form or the attached Notice, please contact our Privacy Official, Erik Zudans.

Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

It was emergency treatment	____
I could not communicate with the patient	____
The patient refused to sign	____
The patient was unable to sign	
Because (please describe)	____

_____
Signature of privacy official

Erik Z. Zudans DMD, PA
NOTICE OF PRIVACY PRACTICES

1. Your Information. **2. Your Rights.** **3. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:

- get a copy of your paper or electronic medical record.
- correct your paper or electronic medical record.
- request confidential communication.
- ask us to limit the information we share.
- get a list of those with whom we've shared your information.
- get a copy of this privacy notice.
- choose someone to act for you.
- file a complaint if you believe your privacy rights have been violated.

Your Choices
You have some choices in the way that we use and share information as we:

- tell family and friends about your condition.
- provide disaster relief.
- include you in a hospital directory.
- market our services and sell your information.
- raise funds.

Our Uses and Disclosures
We may use and share your information as we:

- treat you.
- run our organization.
- bill for your services.
- help with public health and safety issues.
- do research.
- comply with the law.
- respond to organ and tissue donation requests.
- work with a medical examiner or funeral director.

- address workers' compensation, law enforcement, and other government requests.
- respond to lawsuits and legal actions.

More detailed information on each of these three areas follows.

1. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, in a timely manner, without delay for legal review, usually within 30 days of your request. We may charge a reasonable cost-based fee for copying as authorized by the Florida Board of Dentistry but we will not condition copying upon payment of a fee for services rendered.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the information listed at the bottom of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services. Upon request, we will provide you with the address to file a complaint with the U.S. Department of Health and Human Services.
- We will not retaliate against you for filing a complaint.

2. Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- share information with your family, close friends, or others involved in your care.
- share information in a disaster relief situation.
- include your information in a hospital directory.

If you are not able to tell us your preference, (for example, if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also

share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission and the written permission specifically lists the type of information being disclosed and prevents re-disclosure:

- Marketing purposes
- Sale of your information
- Most sharing of notes regarding psychotherapy, HIV and/or substance abuse.

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

3. Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations, such as:

- preventing disease.
- helping with product recalls.
- reporting adverse reactions to medications.
- reporting suspected abuse, neglect or domestic violence.
- preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests

We can use or share health information about you:

- for workers' compensation claims.
- for law enforcement purposes or with a law enforcement official.
- with health oversight agencies for activities authorized by law.
- for special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our web site.

Other Information

- We do not create or manage a hospital directory.
- We do not create or maintain psychotherapy and/or substance abuse information at this practice.
- We do not receive financial remuneration for marketing products or services in this practice.
- We do not sell patient information in this practice.
- We do not engage in fundraising at this practice.
- We do not engage in research studies at this practice.
- We may ask about HIV status because it is pertinent to your dental care but will make no further disclosure of such information without specific written consent from you or as otherwise required by law.
- We will never share any psychotherapy, HIV or substance abuse records without your written permission. A general authorization for release of records is **not** sufficient for us to release this type of information. We will ask you to sign a separate written consent form that specifically mentions this type of information before we release this type of information. If you direct us to release this type of information, we will instruct the recipient that further disclosure by the recipient requires your specific written consent.
- Under Florida law, we are unable to submit claims to payers (your health plan) under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing a Consent form but, unless you pay in full out-of-

pocket, we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or revoke it.

- Effective Date of this Notice is Sept. 23, 2013.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, have a question or have a concern about your personal information, please contact us as indicated below:

Our Privacy Official: Dr. Erik Zudans

Telephone: 561-746-7436

Fax: 561-746-7437

Address: 725 N. Hwy A1A Ste. D-107 Jupiter, FL 33477

Email: DrZudans@gmail.com

Erik Z. Zudans DMD, PA

CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

I, _____,(hereafter "Patient") hereby authorize Erik Z. Zudans DMD, PA
(hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning Patient in accordance with the attached Notice of Privacy Practices (NOPP). I have received a copy of and reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release and hold Practice, its employees and agents harmless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

_____

By Patient: Date:

(Print name and sign)

Or

_____

By Patient's Representative Date:

(Print name, sign, and describe authority)

Note: Do not use this form for disclosure of HIV, Substance Abuse or Psychotherapy Notes.