

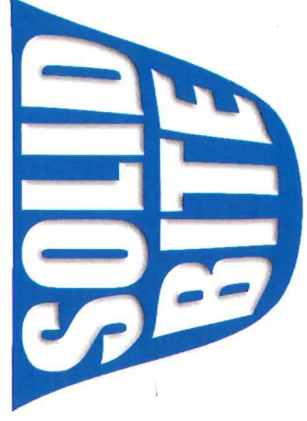
Please Before You Come In

1. Plan to arrive at least 10 minutes early so we can assure all paper work is complete and you can be taken back to see the doctor on time.
2. Refrain from wearing any scented colognes, perfumes, lotions or deodorants. Many of our staff and patients are severely allergic.
3. Keep all jewelry worn from the neck up at home, most likely we will need to do a CT Scan the day of your new patient exam and will need all of this removed. For some patients this takes a lot of time and sometimes these valuables are left behind, they are safer at home.

Thank you!! See you soon 😊



Dr. Michel Furtado
Dr. Lee Sheldon
Dr. Matthew Sheldon



Predictable,
 Life Changing
 Dentistry

Thank you for choosing our office. Below you will find just some of the reasons why Solid Bite is known as the "go to" office for complex dental needs. And if complex is our routine, imagine how well your simple dental needs will be attended to.



OTHERS

All work warranted	✓
Trained specialists doing the surgery	✓
Specialists and generalists collaborating in one office	✓
Same practice for over 30 years and referred to by over 100 doctors	✓
All-Ceramic full arch restorations (vs. acrylic)	✓
"Goop-free" digital impressions	✓
Custom abutments or screw-retained crowns on all single-tooth implants	✓
PRF using your own platelets to speed healing	✓
CT Scan planning for all implants	✓
All fees and full plan given up front	✓
Osstell implant stability meter to increase success	✓
Over 10,000 implants placed	✓
Immediate implant placement after extraction	✓
Immediate temporary on implant	✓
Perioscopy for periodontal treatment instead of surgery	✓
Pinhole graft to increase gum tissue without a scalpel	✓
Metal-Free zirconia implants available	✓
IV sedation available, Anesthesiologist on staff	✓
Surgical guides designed and fabricated on site	✓
Periodontists and hygienists to maintain your work	✓
DNA testing of oral bacteria	✓
Thousands of happy patients who refer others	✓

MEDICAL-DENTAL HISTORY

Name (Mr., Ms., Mrs.): _____ What should we call you? _____
Address: _____ Date of birth: _____
City: _____ Zip Code: _____ Age: _____
Home Phone: _____ Occupation: _____
Cell Phone: _____ Employer: _____
Work Phone: _____ E-Mail: _____
Referred by: _____ Hobbies: _____
Name of Dentist: _____ Dental Insurance: Yes No
Name of Family Physician: _____ Emergency Contact: _____
Name of Cardiologist: _____
Name of Pain Management Physician: _____

Office staff only

Blood pressure _____ Pulse _____
Maximum opening _____ Mallampati Score _____
Height _____ Weight _____

1. Are you currently under the care of a physician? Yes No
2. Please list dates and reasons for hospitalizations _____

3. Please list medications and explain what they are for (ex: Benzapril-HBP) _____

4. Please list allergies to drugs or medications _____

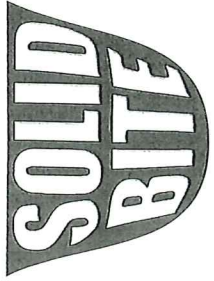
Have you ever been treated for the following conditions?:

5. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? If yes, please specify _____
6. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? If yes, please specify. _____

Have you ever or are you currently been treated for the following conditions?:

7. Excessive bleeding: Yes No List medications and dosage: _____
8. Breathing problems, asthma, tuberculosis, hay fever: Yes No List medications and dosage: _____
9. Cancer, x-ray treatment, or chemotherapy: Yes No List medications and dosage: _____
10. Hepatitis, jaundice, or liver disease: Yes No List medications and dosage: _____
11. Kidney problems or renal dialysis: Yes No List medications and dosage: _____
12. Venereal disease or AIDS: Yes No List medications and dosage: _____
13. A stroke, convulsions, or fainting spells: Yes No List medications and dosage: _____
14. Tumors or growths: Yes No List medications and dosage: _____
15. Arthritis or rheumatism: Yes No List medications and dosage: _____
16. High cholesterol: Yes No List medications and dosage: _____
17. High blood pressure: Yes No List medications and dosage: _____
18. Diabetes: Yes No List medications and dosage: _____

If yes: Type 1 Type 2 What was your last A1C score: _____ Date of last A1C: _____



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Acknowledgement of Receipt of Notice of Privacy Practices

You may Refuse to sign this acknowledgment

I _____ hereby acknowledge that I have reviewed and received a copy of this practice's Notice of Privacy Practices, which has been updated for the new Omnibus Rule and has an effective date of 09/23/13.

The notice describes:

- the ways that the Privacy Rule allows our practice to use and disclose protected health information. How our practice will get your permission, or authorization, before using your health records for any other reason.
- the practice's duties to protect health information privacy.
- the patient's privacy rights, including the right to complain to HHS and to the covered entity if you believe your privacy rights have been violated.
- how to contact our practice for more information and to make a complaint.

I understand that the Notice of Privacy Practices may be revised from time to time and that I have a right to receive an updated copy upon request.

PATIENT 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
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

"THE ANSWER TO FAILING DENTISTRY"

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2223 Sarno Road • Melbourne, FL 32935 www.SolidBite.com

HIPAA NOTICE OF PRIVACY PRACTICES

Lee N. Sheldon, DMD, PA

Effective Date: September 23, 2013

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.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.

You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 321-259-9980.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each.

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior

Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

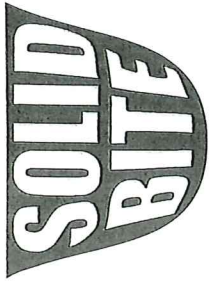
To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court



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Health Information Release Form

In order to assist you in receiving your health information from our office, please complete this form. I, authorize the persons listed below to have access to any and all of my health information. This office is permitted to share any information with them that is disclosed during office visits.

Persons authorized to receive my information (full name, relationship and phone number):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

___ You may notify me or the parties listed above with any information regarding my treatment including appointment reminders, treatment information or prescriptions as follows:

Please mark below which you authorize

___ Message on home answering machine

___ Message work voicemail

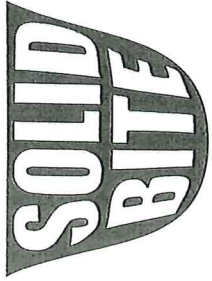
___ Message on cell phone

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____	_____
Print Name	Patient Signature
_____	_____
Patient Date of Birth	Today's Date

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YOUR SIGNATURE IS NECESSARY FOR US TO:

1. *Process all insurance claims,*
2. *To ensure payment for services rendered,*
3. *To release medical information to insurance companies, AND*
4. *To release and/or obtain information to/from other medical/dental providers, when necessary, for your treatment.*

I, authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care

Patient Signature: _____ Date: _____

Responsible Party: _____

(Parent, if Minor ONLY)

Office Use Only:

Witness: _____

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OFFICE POLICY

We are happy to have you with our practice and we anticipate that you will have a successful result. We will do everything that we can to be sure that you have the most pleasant and comfortable experience possible.

The following are the rules that this practice lives by and that we are asking that you comply with:

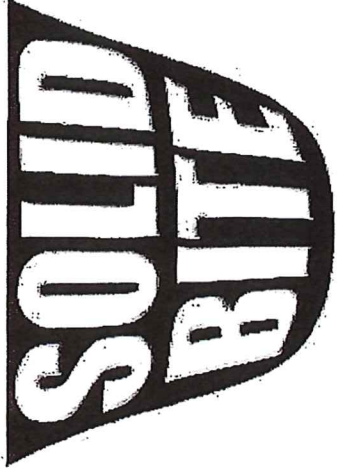
1. **PAYMENT.** Payment for services are arranged on a separate financial arrangement sheet. In order to obtain the best service possible, payments must comply to the financial arrangement that you have agreed to. Failure to pay on time will result in delay in treatment.
2. **CANCELLATIONS.** When making an appointment with this office, a substantial amount of time is reserved for you. We ask that you arrange your schedule in such a way that you are able to make it for every appointment that you have scheduled. Any changes in an appointment with less than a 24-hour notice is considered a "last minute cancellation." If there is a need for a last-minute cancellation, you will be reminded about this policy by our receptionist. If there is a second cancellation within 24 hours of your scheduled appointment, you may be charged for that appointment. A third last-minute cancellation will be reviewed by the office manager and the doctor and may mean dismissal from this practice.
3. **INSURANCE.** We will be happy to give you all the forms necessary to submit to your insurance company for reimbursement after treatment. We do not file Medicare.
4. **EMERGENCIES.** Since this is a surgical office, occasionally we will run behind schedule due to treating patients' emergencies. We ask for your understanding in this matter. If you were to have an emergency, we would accommodate you in the same manner.
5. *Please be aware that Dr. Lee Sheldon is severely allergic to dogs. We understand if you need to bring a certified service dog for a medically needed condition, but for any other reasons, please refrain from bringing dogs into the practice. For those that need to bring a certified service dog, please let us know before arriving so we can make arrangements for Dr. Sheldon. Thank You.*

We thank you for your understanding as these rules are designed to increase efficiency in our office and, therefore, keep your costs down.

All of us at Dr. Sheldon's office look forward to bringing you the best of care in the most comfortable environment from start to finish. We look forward to treating you, your friends, and your loved ones.

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What is Unique about Solid Bite?

1. All Solid Bite services are supervised by Dr. Lee Sheldon, a periodontist with over thirty years of experience and implant experience of well over twenty years.
2. All Solid Bite hybrid services take advantage of CT scan technology as well as the latest in computer software design. The CT scan that we use delivers 2% of the radiation of a conventional medical CT scan. Using the CT scan provides:
 - a. A precise dental implant plan developed on the computer.
 - b. Creation of precision surgical guides based on the computer design. This means minimal incisions or sometimes no incisions for your dental implant surgery.
 - c. Attention to cosmetic detail. You have the opportunity to look at, approve, and make changes to your new teeth before final processing.
3. All of our work is guaranteed. You must be happy with the final result or we will continue to work until you are happy with the final result.
4. All Solid Bite doctors subscribe to the above plan.
5. Guaranteed fees. Once you have approved the final plan, we will not change fees. The fee that you pay is the fee, period.
6. Your treatment coordinator is your resource and is there to answer your questions at any time during business hours. If your treatment coordinator cannot get to the phone when you call, she will call you within twenty-four hours.
7. Twenty-four hour, seven days a week emergency on-call doctor.
8. A board-certified medical anesthesiologist for safe and effective sedation.
9. Experience. Dr. Sheldon was the first dentist in all of Central Florida to use computer design technology for dental implant placement.
10. Training. All Solid Bite doctors continually educate ourselves to be sure that you are getting the latest in technology and, at the same time, receive the personal touch to provide the best in cosmetics and function.
11. Temporary fixed teeth can often be placed on the same day as implant surgery.