



# WELCOME to CENTRAL FLORIDA PERIODONTICS & IMPLANTOLOGY INC.

## Patient Information:

Please choose one: \_\_\_Mr. \_\_\_Mrs. \_\_\_Miss \_\_\_Ms. \_\_\_Dr.

Name: \_\_\_\_\_

Nickname, if any: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_ email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Referral information: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Spouse Information: \_\_\_\_\_

Your spouse's name: \_\_\_\_\_

Employer and Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

## Dental Insurance Information:

Insured's Name: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Group/Policy No.: \_\_\_\_\_

## Emergency Contacts:

Name: \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship \_\_\_\_\_

I understand that I am primarily responsible for payment to the office of Central Florida Periodontics And Implantology, Inc. Jeffrey J. Sevor, D.M.D. I also understand that as a courtesy to me this office will submit a bill to my insurance company for billable services I may receive. In the event my insurance does not cover any part of all the charges associated with my treatment I promise to immediately make payment for these services at the time of my visit.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Today's Date

## MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have a personal physician?  Yes  No

Physician's name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Date of last physical: \_\_\_\_\_

Date of last hospitalization: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

Please explain:

Your current physical health is (check one)  good  fair  poor

Do you PREMED for dental visits?  Yes  No

If yes, what is the reason for PREMED? \_\_\_\_\_

Do you smoke?  Yes  No E-Cigarettes?  Yes  No

Do you use recreational drugs?  Yes  No

What is your weight? \_\_\_\_\_ Height \_\_\_\_\_ Age \_\_\_\_\_

### For Women:

Are you pregnant?  Yes  No

Are you nursing?  Yes  No

Are you taking birth control pills?  Yes  No

Do you have or have you had any of the following? Please check yes or no:

Y\_\_\_\_N\_\_\_\_ Heart Attack / Stroke

Y\_\_\_\_N\_\_\_\_ Psychiatric Problems

Y\_\_\_\_N\_\_\_\_ Cancer / Chemotherapy

Y\_\_\_\_N\_\_\_\_ Epilepsy / Seizures / Fainting Spells

Y\_\_\_\_N\_\_\_\_ Heart Murmur

Y\_\_\_\_N\_\_\_\_ Diabetes / Tuberculosis (TB)

Y\_\_\_\_N\_\_\_\_ Heart Surgery/ Pacemaker

Y\_\_\_\_N\_\_\_\_ Heart Disease / Irregularities / AFIB

Y\_\_\_\_N\_\_\_\_ Shingles

Y\_\_\_\_N\_\_\_\_ Ulcers / Colitis / Diverticulitis

Y\_\_\_\_N\_\_\_\_ Mitral Valve Prolapse

Y\_\_\_\_N\_\_\_\_ Congenital Heart Defect

Y\_\_\_\_N\_\_\_\_ Artificial Joints / Bones

Y\_\_\_\_N\_\_\_\_ Anemia / Radiation Treatment

Y\_\_\_\_N\_\_\_\_ Sinus Problems

Y\_\_\_\_N\_\_\_\_ Difficulty Breathing / Asthma

Y\_\_\_\_N\_\_\_\_ High / Low Blood Pressure

Y\_\_\_\_N\_\_\_\_ Hepatitis / Liver Disease

Y\_\_\_\_N\_\_\_\_ HIV+ /AIDS

Y\_\_\_\_N\_\_\_\_ Chronic Fever Blisters

Y\_\_\_\_N\_\_\_\_ Severe / Frequent Headaches

Y\_\_\_\_N\_\_\_\_ Blood Transfusions

Y\_\_\_\_N\_\_\_\_ Arthritis

Y\_\_\_\_N\_\_\_\_ Glaucoma

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. I also understand that Dr. Sevor will rely upon my representations herein as accurate and it is my responsibility to inform this office of any changes in my medical status. I also understand that this information will be held in the strictest of confidence.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

I have verbally reviewed this information with the patient \_\_\_\_\_ (Doctor's initials) \_\_\_\_\_ (Date)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**MEDICATION LIST**

Your treatment can be affected by any medication that you take and it is important that your physician has updated and correct information.

List all medications (including non-prescription) that you are currently taking:

Medication	Reason	Dose	Frequency

Pharmacy / Address / Phone No. \_\_\_\_\_

**ALLERGIES**

List all medication allergies

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_  
Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Are you allergic to any of the following?

Penicillin \_\_\_\_\_ Tetracycline \_\_\_\_\_ Latex Gloves \_\_\_\_\_  
Aspirin \_\_\_\_\_ Dental Anesthetics \_\_\_\_\_ General Anesthetics \_\_\_\_\_  
Erythromycin \_\_\_\_\_ Codeine \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_  
Patient's Initials

\_\_\_\_\_  
Date

**CENTRAL FLORIDA PERIODONTICS**

**AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS**

I hereby authorize the release or use of my individually identifiable health information (“protected health information”) and medical record information by Central Florida Periodontics (the “Practice”) in order to carry out treatment, payment, or health care operations. You should review the Practice’s Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

**I agree and consent to the Practice releasing information to me in the following alternative manner(s) (please initial the appropriate spaces below):**

\_\_\_\_\_ Via e-mail to the Patient’s designated e-mail address which is: (I am responsible for notifying the practice of any changes to my e-mail address.)

\_\_\_\_\_ Via **regular mail** with any envelopes being marked personal and confidential and addressed to me.

\_\_\_\_\_ Via **telephone**, if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier).

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

\_\_\_\_\_  
Signature of Patient or authorized representative

\_\_\_\_\_  
Please print Name

**FOR OFFICE USE ONLY**

Patient refused to sign.  
The following circumstances prohibited the patient from signing the Acknowledgement \_\_\_\_\_  
An emergency situation prevented the patient (parent/guardian) from signing the acknowledgement.

\_\_\_\_\_  
Office Personnel (signature)

\_\_\_\_\_  
Office Personnel (print name)

Date: \_\_\_\_\_



## **Your Information. Your Rights. 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**

**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, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **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.

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## Your Rights *continued*

### 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.

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### 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.

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### 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.

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### 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.

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### 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 on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.
- We will not retaliate against you for filing a complaint.

## 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
- Contact you for fundraising efforts

*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:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**In the case of fundraising:**

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

## 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.

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**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. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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**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

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**Do research**

- We can use or share your information for health research.

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**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.

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**Respond to organ and tissue donation requests**

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

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**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.

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**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

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**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.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### 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.

*Effective March 12, 2019*

### **This Notice of Privacy Practices applies to the following organizations.**

*This notice applies to both of our locations:*

*Central Florida Periodontics & Implantology*

*2295 Lee Road,  
Winter Park, FL 32789*

*1340 Tuskawilla Road, Suite 108  
Winter Springs, FL 32708*

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*Compliance Officer: Linda Jung  
email: [centralfloridaperio@mindspring.com](mailto:centralfloridaperio@mindspring.com)  
Phone: 407-647-2295 Fax: 407-647-0354*