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 cardiologist?_____Yes ______ No
Cardiologist Name______________________ Phone No.:______________
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:

Yes	No	
		Anemia
		Blood Transfusions
		Arthritis
		Artificial Joints / Bones
		Asthma
		Cancer
		Chemotherapy
		Radiation Treatment
		Chronic Fever Blisters
		Diabetes
		Difficulty Breathing
		Epilepsy
		Seizures
		Fainting Spells

Yes	No	
		Glaucoma
		Hepatitis
		Liver Disease
		HIV+
		AIDS
		Psychiatric Problems
		Severe / Frequent Headaches
		Shingles
		Sinus Problems
		Tuberculosis (TB)
		Ulcers
		Colitis
		Diverticulitis

Heart Problems Yes No

Check all that apply:

Blood Pressure High Low
Heart Attack
Stroke
Heart Murmur
Congenital Heart Defect
Heart Surgery
Pacemaker
Heart Disease
Irregularities
AFIB
Mitral Valve Prolapse

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

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1998 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosure of your information in connection with providing or coordinating your treatment. The following situations do not require us to obtain your permission to disclose your information: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____________________________ ____

Patient Signature Patient Name (please print)

I am also signing for my minor children: ____

(please print names)

Date: ____________________

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment, I understand that such disclosures may not be of the type listed above.

__________________________________ _____________________________________

Patient Signature Patient Name (please print)

I am also signing for my minor children: ____

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child caregiver)

____

(please print names)

____

Date: _________________

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: _______________________________

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

Central Florida Periodontics & Implantology
Jeffrey J. Sevor, DMD

2295 Lee Road, Winter Park, FL 32789
https://centralfloridaperio.com

Phone: 407-647-2295

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.

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 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/.** • 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.**

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.

For more information see: **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

Compliance Officer: Linda Jung
email: centralfloridaperio@mindspring.com
Phone: 407-647-2295 Fax: 407-647-0354