Village Periodontics &
DENTAL IMPLANT CENTER

PATIENT INFORMATION FORM

IN ORDER THAT WE MAY BETTER SERVE YOU, PLEASE COMPLETE IN FULL

TODAY'S DATE _____ EMAIL_____

NAME _____ PREFERRED NAME _____ SEX ◯ M ◯ F

DATE OF BIRTH _____MARITAL STATUS ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME # (_____) _____-_____WORK # (_____) _____-_____CELL# (_____) _____-_____

PREFERRED FORM OF CONTACT ◯ PHONE CALL ◯ TEXT MESSAGE ◯ EMAIL

HAS ANYONE IN YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? ◯ YES ◯ NO NAME _____

SPOUSE'S/PARTNER'S NAME _____ CELL# (_____) _____-_____

EMERGENCY CONTACT _____ RELATIONSHIP _____ CONTACT # (____) _____-_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

ARE YOU COMPLETING THIS FORM FOR ANOTHER PERSON? ◯ YES ◯ NO

IF SO, YOUR NAME _____ RELATIONSHIP TO PATIENT _____

RESPONSIBLE PARTY INFORMATION (IF NOT PATIENT)

NAME OF RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____CITY _____STATE _____ ZIP _____

HOME # (_____) _____-_____WORK # (_____) _____-_____CELL# (_____) _____-_____

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

DENTAL INSURANCE INFORMATION

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DOB _____

SUBSCRIBER'S SS# _____ NAME OF EMPLOYER OR SELF _____ EMPLOYEE # _____

INSURANCE COMPANY _____ GROUP # _____ LOCAL #_____

INSURANCE COMPANY'S ADDRESS _____

Patient Name: _____

DENTAL HISTORY

WHO IS YOUR DENTIST? _____ PHONE # (_____) _____-_____

WHAT IS YOUR UNDERSTANDING AS TO WHY YOU WERE REFERRED TO OUR OFFICE? _____

_____

HOW WOULD YOU RATE YOUR ORAL HEALTH 1-10? (1 BEING VERY POOR, 10 BEING VERY HEALTHY) _____

HOW SATISFIED ARE YOU WITH YOUR RATING OF YOUR ORAL HEALTH? _____

IN YOUR OPINION, WHAT DOES A HEALTHY MOUTH LOOK LIKE? _____

_____

HOW WOULD YOU RATE YOUR CHEWING ABILITY ON A SCALE OF 1-10 (1 BEING VERY POOR, 10 BEING PERFECT) _____

WHAT WOULD AN 8 FEEL LIKE FOR YOU? _____

WHAT DO YOU ENJOY EATING THAT YOU CAN'T EAT NOW? _____

◯ YES ◯ NO ARE YOU APPREHENSIVE ABOUT DENTAL TREATMENT? IF YES, PLEASE EXPLAIN WHAT IS THE CAUSE?

_____

DATE OF LAST CLEANING _____FREQUENCY OF CLEANINGS OR MAINTENANCE VISIT_____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____DAILY ◯ YES ◯ NO DO YOU USE DENTAL FLOSS?

DO YOU USE ANY INTERDENTAL AIDS (SUCH AS PROXA BRUSHES)? IF YES, WHAT? _____

◯ YES ◯ NO HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE? SUCH AS: DEEP CLEANINGS, GUM GRAFTING, PERIODONTAL SURGERY; IF SO, WHAT TYPE OF TREATMENT AND WHEN? _____

_____

WHAT IS MOST IMPORTANT TO YOU WITH YOUR ORAL HEALTH? _____

HAVE YOU **HAD** OR DO YOU CURRENTLY **HAVE**? (PLEASE CHECK YOUR ANSWERS)

◯ YES ◯ NO RECENT PAIN IN MOUTH OR FACE

◯ YES ◯ NO BLEEDING GUMS

◯ YES ◯ NO LOOSE TEETH

◯ YES ◯ NO BAD BREATH

◯ YES ◯ NO UNPLEASANT TASTE

◯ YES ◯ NO FOOD IMPACTION

◯ YES ◯ NO SWELLING OR LUMPS IN MOUTH

◯ YES ◯ NO TEETH SENSITIVE TO HOT, COLD, SWEET

◯ YES ◯ NO CLENCHING OR GRINDING OF TEETH

◯ YES ◯ NO ORTHODONTIC (BRACES) TREATMENT

◯ YES ◯ NO MOUTH BREATHING

◯ YES ◯ NO POPPING, CLICKING OR SORENESS IN THE JOINTS IN FRONT OF EARS

Patient Name: _____

MEDICAL INFORMATION

PHYSICIAN _____ SPECIALTY _____ DATE OF LAST VISIT _____
FIRST NAME LAST NAME

CITY _____ STATE _____ PHONE # (_____)_____-_____

◯ YES ◯ NO ARE YOU UNDER THE CARE OF **ANOTHER PHYSICIAN**? IF YES, WHY? _____

_____

◯ YES ◯ NO HAVE YOU BEEN TOLD YOU NEED TO **PREMEDICATE** OR TAKE ANTIBIOTICS PRIOR TO A DENTAL PROCEDURE? WHICH ANTIBIOTIC DO YOU TAKE? _____FOR WHAT CONDITION? _____

MEDICATIONS

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING SUPPLEMENTS, SUCH AS VITAMINS AND INHALERS.

DRUG _____ DOSE _____ DRUG _____ DOSE _____
DRUG _____ DOSE _____ DRUG _____ DOSE _____
DRUG _____ DOSE _____ DRUG _____ DOSE _____
DRUG _____ DOSE _____ DRUG _____ DOSE _____

ARE YOU CURRENTLY TAKING OR HAVE YOU TAKEN ANY OF THE MEDICATIONS LISTED BELOW?

OSTEOPOROSIS OR BONE STRENGTHENING MEDICATIONS

◯ YES ◯ NO FOSAMAX® (ALENDRONATE) YRS___
◯ YES ◯ NO ACTONEL® (RISEDRONATE) YRS___
◯ YES ◯ NO BONIVA® (IBANDRONATE) YRS___
◯ YES ◯ NO AREDIA® (PAMIDRONATE)
◯ YES ◯ NO PROLIA® (DENOSUMAD)
◯ YES ◯ NO ZOMETA® (ZOLEDRONATE)
◯ YES ◯ NO RECLAST® (ZOLEDRONIC ACID) YRS___
DATE OF LAST INFUSION _____

BLOOD THINNER

◯ YES ◯ NO PLAVIX® (CLOPIDOGREL BISULFATE)
◯ YES ◯ NO ASPIRIN®
◯ YES ◯ NO EFFIENT® (PRASUGREL)
◯ YES ◯ NO BRILINTA® (TICAGRELOR)
◯ YES ◯ NO COUMADIN® (WARFRIN)
◯ YES ◯ NO PRADAXA® (DABIGATRAN)
◯ YES ◯ NO XARELTO® (RIVAROXABAN)
◯ YES ◯ NO ELIQUIS® (APIXABAN)

IF YES TO **COUMADIN**, WHAT WAS YOUR LAST **INR**?
_____ LAST DATE CHECKED _____

MEDICATIONS FOR THE TREATMENT OF CONDITIONS, SUCH AS: *PSORIASIS, ULCERATIVE COLITIS, AND ARTHRITIS*

◯ YES ◯ NO HUMIRA® (ADALIMUMAD) DOSAGE_____, FREQUENCY_____
◯ YES ◯ NO EMBREL® (ETANERCEPT) DOSAGE_____, FREQUENCY_____
◯ YES ◯ NO REMICADE® (INFLIXIMAB) DOSAGE_____, FREQUENCY_____
◯ YES ◯ NO STEROIDS DOSAGE_____, FREQUENCY_____
◯ YES ◯ NO METHOTREXATE DOSAGE_____, FREQUENCY_____

◯ YES ◯ NO HAVE YOU BEEN **HOSPITALIZED** FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?
IF YES, WHEN AND FOR WHAT? _____

_____

◯ YES ◯ NO ARE YOU CURRENTLY USING ANY **TOBACCO** PRODUCTS? IF YES, HOW OFTEN AND FOR HOW LONG?

_____

◯ YES ◯ NO DO YOU DRINK **ALCOHOL**? IF YES, AVERAGE DAILY ALCOHOL CONSUMPTION? _____

◯ YES ◯ NO HAVE YOU EVER HAD TREATMENT FOR **DRUG** OR **ALCOHOL** PROBLEMS?

◯ YES ◯ NO ARE YOU **ALLERGIC** TO ANY DRUGS OR MEDICINE (INCLUDING ANESTHESIA)?

IF YES, WHICH ONES? _____

◯ YES ◯ NO ARE YOU ALLERGIC TO LATEX OR ANY RUBBER PRODUCTS?

Patient Name: _____

DO YOU CURRENTLY HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING?

CARDIOVASCULAR

◯ YES ◯ NO HIGH BLOOD PRESSURE
◯ YES ◯ NO HEART DISEASE
IF YES, PLEASE EXPLAIN _____
◯ YES ◯ NO HEART ATTACK (MI)
IF YES, WHEN? _____
◯ YES ◯ NO MITRA VALVE PROLAPSE/MURMUR
◯ YES ◯ NO CARDIAC PACEMAKER
◯ YES ◯ NO ANGINA/CHEST PAIN
◯ YES ◯ NO HEART INFECTION/ENDOCARDITIS
◯ YES ◯ NO HEART SURGERY/STENTS
IF YES, WHEN? _____
◯ YES ◯ NO PERIPHERAL VASCULAR NEUROPATHY
OTHER: _____

RESPIRATORY

◯ YES ◯ NO ASTHMA
IF YES, WHAT TRIGGERS IT?_____
◯ YES ◯ NO SHORTNESS OF BREATH
◯ YES ◯ NO EMPHYSEMA
◯ YES ◯ NO TUBERCULOSIS
◯ YES ◯ NO CHRONIC OBSTRUCTIVE PULMONARY DISEASE
◯ YES ◯ NO SINUS PROBLEMS
OTHER: _____

NEUROLOGIC

◯ YES ◯ NO FAINTING/SEIZURES
◯ YES ◯ NO EPILEPSY/CONVULSIONS
◯ YES ◯ NO STROKE IF YES, WHEN? _____
◯ YES ◯ NO TRANSIENT ISCHEMIC ATTACK (TIAs)
◯ YES ◯ NO FIBROMYALGIA
◯ YES ◯ NO TRIGEMINAL NEURALGIA
OTHER: _____

INFECTIOUS DISEASES/IMMUNE PROBLEMS

◯ YES ◯ NO ORGAN TRANSPLANT
◯ YES ◯ NO AIDS OR HIV INFECTION
◯ YES ◯ NO HEPATITIS: CIRCLE TYPE A B C
◯ YES ◯ NO INFECTIOUS/SEXUALLY TRANSMITED DISEASE

ENDOCRINE

◯ YES ◯ NO HAS ANY BLOOD RELATIVE HAD DIABETES
◯ YES ◯ NO THYROID/PARATHYROID PROBLEMS
◯ YES ◯ NO LIVER DISEASE
◯ YES ◯ NO JAUNDICE
◯ YES ◯ NO SJOGREN'S SYNDROME
◯ YES ◯ NO DIABETES MELLITUS
IF YES, WHAT WAS YOUR LAST **A1C**? _____
HOW IS IT CONTROLLED? _____
OTHER: _____

CANCER/BLOOD DISORDERS

◯ YES ◯ NO CANCER
TYPE? _____ WHEN? _____
◯ YES ◯ NO RADIATION OR CHEMOTHERAPY
WHICH AREA? _____
◯ YES ◯ NO ANEMIA
OTHER: _____

STOMACH/INTESTINAL PROBLEMS

◯ YES ◯ NO IRRITABLE BOWEL SYNDROME
◯ YES ◯ NO COLITIS, DIVERTICULITIS
◯ YES ◯ NO CROHN'S DISEASE
◯ YES ◯ NO PSUEDOMEMBRANOUS COLITIS
OTHER: _____

OTHER

◯ YES ◯ NO SWOLLEN ANKLES
◯ YES ◯ NO KIDNEY DISORDERS OR STONES
◯ YES ◯ NO ARTHRITIS
◯ YES ◯ NO JOINT REPLACEMENT/JOINT IMPLANTS
◯ YES ◯ NO FREQUENTLY TIRED
◯ YES ◯ NO HAY FEVER/ALLERGIES
◯ YES ◯ NO GLAUCOMA
◯ YES ◯ NO RECENT WEIGHT LOSS
◯ YES ◯ NO ADVERSE REACTIONS TO ANESTHESIA
◯ YES ◯ NO SLEEP APNEA

WOMEN ONLY

◯ YES ◯ NO HAVE YOU HAD A HYSTERECTOMY?
◯ YES ◯ NO ARE YOU ON BIRTH CONTROL PILLS?
◯ YES ◯ NO ARE YOU PREGNANT OR THINK YOU MAY BE?

PLEASE LIST ANY OTHER CONDITION(S) NOT MENTIONED ABOVE: _____
_____
_____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND, TO THE BEST OF MY KNOWLEDGE, ALL QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY DEPENDENT DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYERS AND/OR HEALTH PRACTITIONERS.

X_____

SIGNATURE OF PATIENT OR PARENT OF MINOR DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could no be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other (Please provide specific details)

_____ _____

Employee signature Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advise and covers only federal, not state, law.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This notice will take effect January 1, 2010 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the change. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting or Privacy Officer, Susan. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: we may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

(a) Right to an Accounting of Disclosures: You have the right to request an *accounting of disclosures* of your protected information if the disclosure was made for purposes other than providing services, payment, and/or business operations. To request this list of accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $____for each page and the staff time charge will be $____per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

(b) Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where "the disclosure is to a health plan for purposes of carrying out payment or health operations (is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

Payments: We may use and disclose your health information to seek payment for services we provide you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use and disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to make reasonable inferences of your best interests by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Health Operations: We will use and disclose your health information to keep our office operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when requested by national security, intelligence and other States and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization o do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made o review your records. Copies, if requested, will be $_____for each page and the staff time charged will be $_____per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: you have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be declined.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment, or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies) Please contact our Privacy Officer if you want further restrict access to your healthcare information. This request must be submitted in writing.

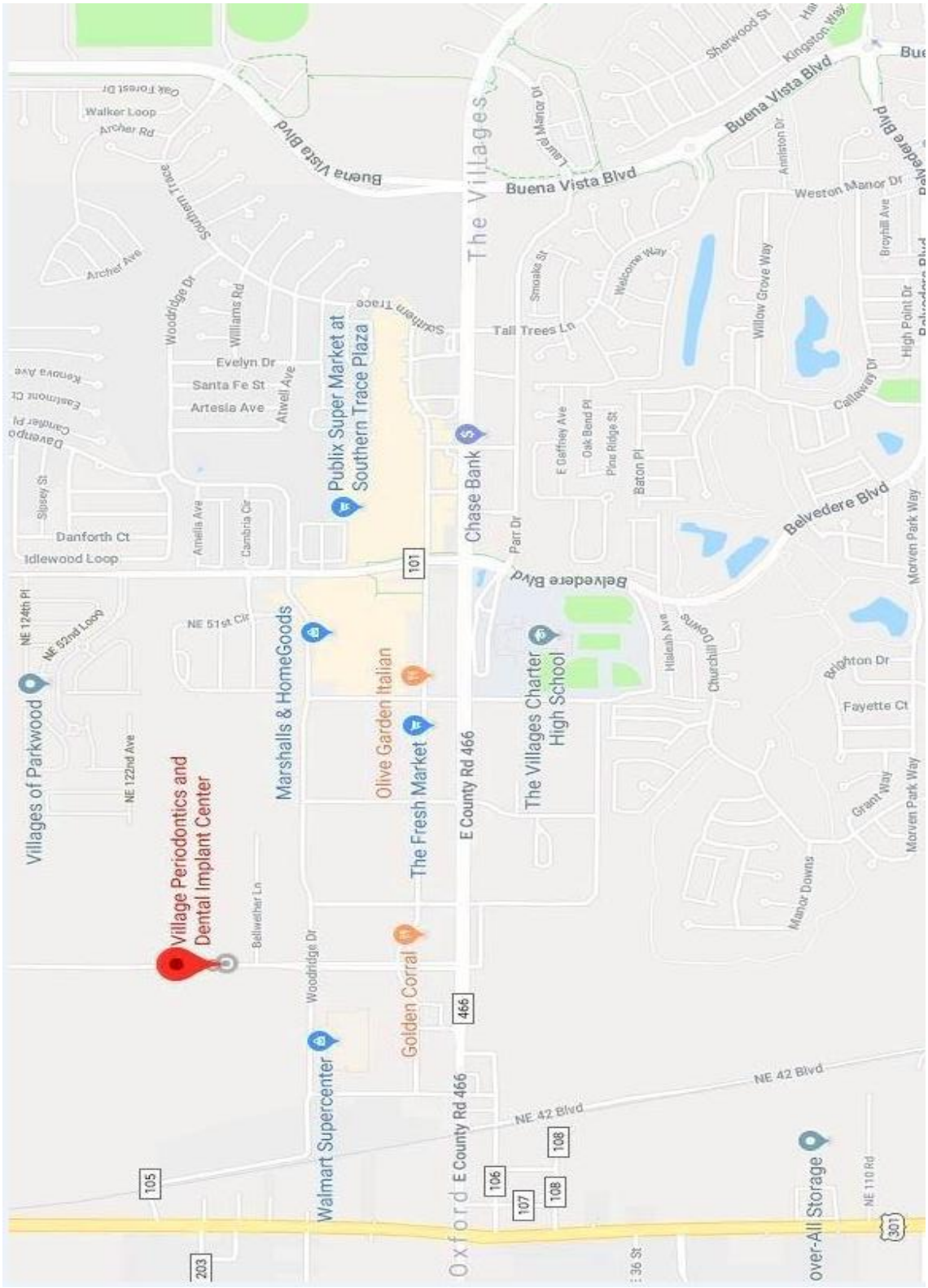
Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

QUESTIONS AND COMPLIANTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may violate your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing, request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Dennis B. Davis, DMD, MS Privacy Officer: Christene Geller
Telephone : 352-259-6799
Address: 12161 CR 103, Suite 101, Oxford, FL 34484
Email: office@villageperiodontics.com


Buena Vista Blvd
The Villages
Sherwood St
Kingston Way
Walker Loop
Archer Rd
Oak Forest Dr
Southern Trace
Archer Ave
Woodridge Dr
Williams Rd
Evelyn Dr
Santa Fe St
Artesia Ave
Atwell Ave
Publix Super Market at Southern Trace Plaza
Tall Trees Ln
Smoke St
Welcome Way
Willow Grove Way
Broyhill Ave
High Point Dr
Weston Manor Dr
Annistion Dr
Callaway Dr
Chase Bank
E Gaffney Ave
Oak Bend Pl
Pine Ridge St
Baton Pl
Parr Dr
Belvedere Blvd
Morven Park Way
Sipsey St
Danforth Ct
Idlewood Loop
Amelia Ave
Cambria Cir
101
NE 124th Pl
NE 52nd Loop
NE 51st Cir
Marshalls & HomeGoods
Olive Garden Italian
The Fresh Market
E County Rd 466
The Villages Charter High School
Hialeah Ave
Churchill Downs
Brighton Dr
Fayette Ct
Grant Way
Villages of Parkwood
NE 122nd Ave
Village Periodontics and Dental Implant Center
Bellwether Ln
Woodridge Dr
Golden Corral
Manor Downs
466
Walmart Supercenter
NE 42 Blvd
105
106
107
108
203
301
NE 110 Rd
over-All Storage