Village Periodontics &
DENTAL IMPLANT CENTER

Village Prosthodontics &
DENTAL IMPLANT CENTER

12161 CR 103 * Suite 101 * Oxford, FL * 34484 * 352-259-6799

PATIENT INFORMATION FORM

PLEASE COMPLETE ALL PAGES

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# (_____) _____ - _____

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? _____

PREFERRED PHARMACY NAME _____ **LOCATION** _____

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 ID# _____ SUBSCRIBER'S SS # _____

INSURANCE COMPANY _____ INSURANCE PHONE # _____

INSURANCE COMPANY'S ADDRESS _____

PLEASE NOTE: We file your insurance as a courtesy. Payment is due at the time of service.

I CERTIFY THAT I HAVE COMPLETED AND REVIEWED MY MEDICAL HISTORY AND MEDICATIONS AND PROVIDED ANY CHANGES TO THE BEST OF MY KNOWLEDGE AND THAT ALL QUESTIONS HAVE BEEN ANSWERED ACCURATELY

_____ _____

PATIENT'S PRINTED NAME PATIENT'S SIGNATURE

Patient Name: _____

DENTAL HISTORY

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

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

_____

ON A SCALE OF 1-10, 1 (IT'S NOT IMPORTANT) 10 (IT'S MOST IMPORTANT) HOW IMPORTANT IS IT TO KEEP YOUR TEETH?

_____

IN YOUR OPINION, WHAT IS YOUR GENERAL DENTAL HEALTH? _____

DATE OF LAST CLEANING _____FREQUENCY OF CLEANINGS OR MAINTENANCE VISIT_____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____DAILY

DO YOU USE ELECTRIC OR MANUAL TOOTH BRUSH? (CIRCLE ONE) DO YOU USE DENTAL FLOSS? ◯ YES ◯ NO

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

PREVIOUS MAJOR DENTAL TREATMENT. PLEASE GIVE DATES AND EXPLANATION: _____

_____

◯ YES ◯ NO DO YOU HAVE ADDITIONAL APPOINTMENTS SCHEDULED WITH YOUR RESTORATIVE DENTIST?

IF YES, WHEN AND FOR WHAT PURPOSE? _____

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

_____

◯ YES ◯ NO ARE YOU CHEWING SATISFACTORILY? IF **NOT** SATISFIED, WHAT WOULD YOU WISH TO CHANGE?

_____

ARE YOU FEARFUL OF DENTAL TREATMENT? HOW FEARFUL ON A SCALE OF 1-10 1(LEAST) 10 (MOST) _____

_____

◯ YES ◯ NO HAVE YOU HAD ORTHODONTIC TREATMENT IN THE PAST?

◯ YES ◯ NO DOES YOUR JAW JOINT EVER HAVE PAIN, SOUNDS (POPPING, CLICKING) OR EXPERIENCED LIMITED OPENING OR LOCKING?

◯ YES ◯ NO HAVE YOU EVER HAD TROUBLE GETTING NUMB OR HAD ANY REACTIONS TO LOCAL ANESTHETIC?

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 MOUTH BREATHING

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 FOSOMAX® (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 ELIQUIS® (APIXABAN)
◯ YES ◯ NO BRILINTA® (TICAGRELOR)
◯ YES ◯ NO COUMADIN® (WARFRIN)
◯ YES ◯ NO PRADAXA® (DABIGATRAN)
◯ YES ◯ NO XARELTO® (RIVAROXABAN)
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/CEREBROVASCULAR

◯ 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
◯ YES ◯ NO TRANSIENT ISCHEMIC ATTACK (TIAs)
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/SEIZURES
◯ YES ◯ NO STROKE IF YES, WHEN? _____
◯ YES ◯ NO FIBROMYALGIA
◯ YES ◯ NO TRIGEMINAL NEURALGIA
◯ YES ◯ NO COGNITIVE IMPAIRMENT/DEMENTIA
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

Notice of Privacy Practices
Village Periodontics & Village Prosthodontics
How we protect your information and privacy

Your Rights:

*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. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable 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.

*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. MINORS: In the case of a minor child where the parents are divorced, we will request a copy of the divorce degree and we will abide by that order. If there is no degree, then we will treat both parents equally and will share information when it is requested. We may or may not advise the other parent that a request for information has been made.

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 healthcare 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 fee if you ask for another one within 12 months.

* Get a copy of this privacy notice

You may receive a written copy of this notice

* 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.

* File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us Village Periodontics & Dental Implant Center and Village Prosthodontics or by contacting the Office of Civil Rights www.hhs.gov/ocr/privacy/hipaa/ complaints

Your Choices:

In certain situations, or conditions, you can tell us your choices about what we can 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 try to follow your instructions.

- In these cases, you have both the right and choice to tell us to:
- Share information with family or close friends involved in your care.
- Share information in a disaster relief situation
  If you are not able to tell us your preference or in the event of an emergency, 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.
- We will never share your information for:
- Marketing purposes
- Fundraising purposes
- Sale your information

Our Uses

- **Treat You**
  We can use your health information and share it with other professionals who are treating you including other dentist and healthcare professionals such as your Cardiologist, Family Physician.
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary and as necessary.
- **Bill for our services.**
  We can use and share your health information to seek payment from health plans, benefit providers or other entities

How else we can use your information?

We are allowed to use your information in other situations or ways that usually affect the public good.

- We can share health information about you for certain situations such as:
  *Preventing diseases
  *Helping with product recalls
  *Reporting adverse reactions to medicines
  *Reporting suspected abuse, neglect, or domestic violence
  *Preventing or reducing a serious threat to anyone's health or safety.
  * Research purposes
  *To comply with state or federal laws
  *To respond to a court order or subpoena
  *Share with coroner or medical examiner or funeral home
  *In the event of an emergency or disaster
  *Workers Compensation Claims
  *For law enforcement purposes
  *For special government functions such as military or national security

Our Responsibilities

We take patient privacy very seriously and attempt to take every precaution and safeguard to protect our patient's health information.

However, if we find that there has been a breach or misuse of your information, we will notify you as soon as possible that your information may have been compromised or misused.
Our Privacy and Security Officer's contact information:
om@villageperiodontics.com
12161 CR 103, Suite 101, Oxford, FL 34484
(352)259-6799

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

***** In the event I am not able to request my records or receive information pertaining to my service rendered at Village Periodontics & Dental Implant Center and Village Prosthodontics, I authorize my information to be released to:**

_____ Relationship: _____ Contact #: _____

_____ Relationship: _____ Contact #: _____

_____ _____ _____

Please print your name | 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, it was not possible to obtain an acknowledgement.

☐ We were unable 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 advice and covers only federal, not state, law.

Village Periodontics & DENTAL IMPLANT CENTER

Village Prosthodontics & DENTAL IMPLANT CENTER

Appointment Cancellation Policy

Village Periodontics & Dental Implant Center and Village Prosthodontics are exercising the right to request our patients to provide at least **48-hours' notice** (two ***business*** days) if an appointment needs to be canceled or rescheduled. This window of time allows us to contact and appoint other patients who are actively seeking sooner availability with our dentists and/or hygienists. Exceptions may be available but must be addressed at the time of the cancellation and are approved on a case-by-case basis. Canceling, rescheduling, or no-showing for appointments without providing at least 48-hours' notice will be considered a "Failed Appointment" for which a $25.00 fee will be assessed; this fee cannot be billed to your dental plan as it is the direct responsibility of the patient.

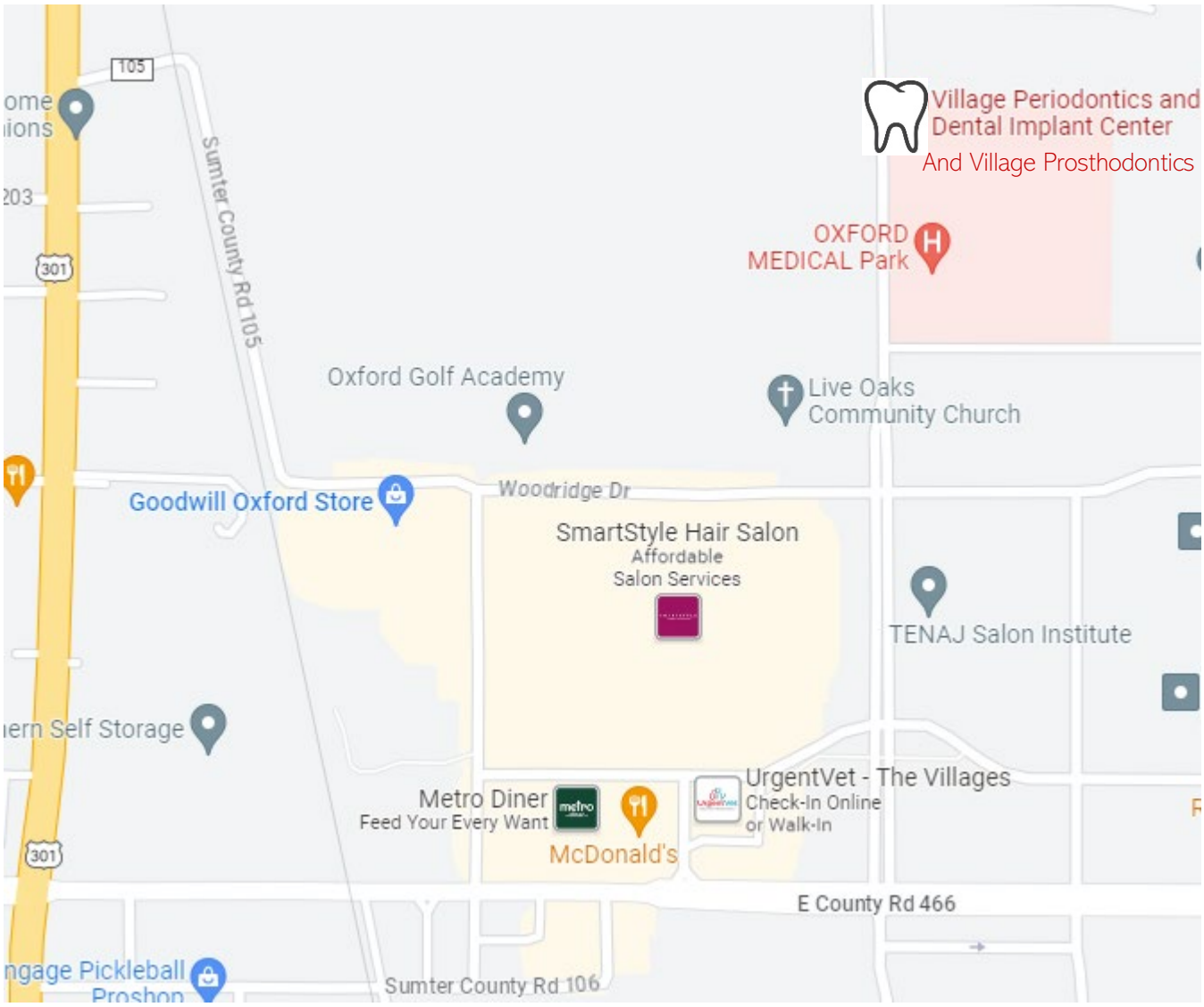
If you have any questions regarding this policy, please contact us at your earliest convenience. We thank you for your continued patronage and we look forward to seeing you on your next visit!

I have read and understand the Appointment Cancelation Policy of Village Periodontics & Dental Implant Center and Village Prosthodontics I agree to its terms. I also understand and agree that such terms may be amended from time-to-time by the practice and that I can request updated policy information at my convenience.

Patient Name: _____ Legal Guardian: _____

Patient/Legal Guardian Signature: _____ Date: _____

Effective as of 3/1/2024


105
Sumter County Rd 105
Village Periodontics and
Dental Implant Center
And Village Prosthodontics
OXFORD
MEDICAL Park
Oxford Golf Academy
Live Oaks
Community Church
Goodwill Oxford Store
Woodridge Dr
SmartStyle Hair Salon
Affordable
Salon Services
TENAJ Salon Institute
Metro Diner
Feed Your Every Want
McDonald's
UrgentVet - The Villages
Check-In Online
or Walk-In
301
E County Rd 466
Sumter County Rd 106