Jorge L. Ramirez, D.M.D.

Practice Limited to Periodontics / Implant Dentistry

○ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Miss (Please select one) Date: ____________

Patient's Name____________ Date of Birth ________ Marital Status:________

Home Address____________ City________ Zip code________ Phone________ Cellular ________

Business Address____________ City________ Zip code________ Phone ________

Email____________ Occupation________ SSN________ Dental Insurance Co. ________

Name of Spouse____________ Occupation________ Business Phone ________

Name of Dentist____________ Address________ Phone________ How Long? ________

Name of Physician____________ Address________ Phone________ How Long? ________

Whom may we thank for referring you to this office? ____________

Whom may we contact in case of an emergency? ____________ Phone ________

Reason for visit ____________

Since periodontal disease is produced by a combination of many complex elements, it is necessary to resolve every possible contributing factor. The success of therapy is most dependent upon this. Though some of the following questions may seem unrelated to your gum condition, they are associated with proper management of your oral health. Your answers are for our records only and will be considered confidential.

1. Are you in good Health? ☐ Yes ☐ No

2. Date of last physical examination ____________ 3. Are you currently being treated by a physician? ☐ Yes ☐ No

3. Are you taking any prescription drugs or medications? ☐ Yes ☐ No

If yes, please list ____________

4. Are you taking any over-the-counter preparations or medications? ☐ Yes ☐ No

If yes, please list ____________

5. Are you allergic to any of the following?

Local anesthetics (Novocaine)........................	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
Barbiturates, sedatives, sleeping pills	☐ Yes	☐ No	Codeine	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No	Other................................	☐ Yes	☐ No
Other antibiotics	☐ Yes	☐ No			

6. Have you had any serious illness, operation or been hospitalized?

If yes, please explain ____________

7. Indicate which of the following you have had or have at the present:

Heart failure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Heart disease or attack	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Prolonged bleeding	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Persistent cough	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Blood transfusion	☐ Yes	☐ No
Rheumatic or scarlet fever	☐ Yes	☐ No	Allergies or hives	☐ Yes	☐ No	Bruise easily	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No	Immune system disorder	☐ Yes	☐ No
Congenital heart lesions	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No	AIDS/ARC/HIV positive	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No	Liver disorder	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No
Heart pacemaker	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Recent weight loss	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Epilepsy or seizures	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Arthritis or rheumatism	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Swollen ankles	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Skin disease	☐ Yes	☐ No	Radiation treatment	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mental disorder	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No	Cold sores / fever blisters	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Kidney disorder	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No	Drug addiction	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Blood disease	☐ Yes	☐ No	Alcohol addiction	☐ Yes	☐ No

8. Do you have any disease, condition or problem not listed here? ☐ Yes ☐ No

If yes, please list ____________

9. In order to prevent complications associated with heart disease, heart murmur, artificial heart valves or artificial joint replacement. it is often necessary to take antibiotics prior to any dental appointment Please contact your physician or our office before your first appointment if you have any questions regarding premedication.

Do you normally premedicate? ☐ Yes ☐ No

10. Do you smoke or chew tobacco? ☐ Yes ☐ No Amount ____________

11. Do you consume alcohol on a regular basis? ☐ Yes ☐ No Amount ____________

12. Do you use recreational drugs? ☐ Yes ☐ No

13. Date of last dental visit ____________________

14. Have you had any problems associated with previous dental treatment? ☐ Yes ☐ No

If yes, please list ____

15. Have you ever had periodontal treatment? ☐ Yes ☐ No

16. Have you ever worn braces? ☐ Yes ☐ No

17. Do you clench or grind your teeth? ☐ Yes ☐ No

18. Do you experience pain in your jaw joints or facial muscles? ☐ Yes ☐ No

19. Do you wear any removable dental appliances? ☐ Yes ☐ No

Women:

20. Are you pregnant? ☐ Yes ☐ No

21. Are you taking birth control pills? ☐ Yes ☐ No How Long ____________

22. Have you reached menopause? ☐ Yes ☐ No

I certify the above to be true.

CONSENT

The undersigned hereby authorizes Doctors to perform all necessary procedures deemed appropriate to make a thorough diagnosis of the patients dental or oral-facial needs including x-rays, study models, photographs. medications and the use of local anesthetic agents. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine. due and payable at the time services are rendered., unless financial arrangements have been made. I further understand that a 1 1/2 percentage finance charge (18" annually) will be added to any balance over 90 days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may require to effect collection of this note.

____

Signature of patient
(parent or guardian, if minor)

Date

For completion by doctor

Significant findings ____

Dental management considerations ____

Medical History Update

Date	Comments	Signature

Periodontal Solutions of South Florida, DDS, PA

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/1/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._ for each page, $_ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or . location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We 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.

Contact Officer: Cristina de las Casas Telephone: 305.665.6575 Fax: 305.661.7076

E-mail: perio@bellsouth.net Address: 7600 Red Road, Suite 216, South Miami, Florida 33143

Periodontal Solutions of South Florida, DDS, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I,____, have received a copy of this office's Notice of Privacy Practices.

____
Print Name

____
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
- ◯ Communications barriers prohibited obtaining the acknowledgement
- ◯ An emergency situation prevented us from obtaining acknowledgement
- ◯ Other (Please Specify)

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