Dr. John L. Redd, II, D.M.D, P.A.

Dear Patient,

Welcome to our practice. My staff and I are delighted that you have chosen us to care for your dental needs. We have put together this welcome package to help us become better acquainted with each other. I feel that the more we know about each other, the better chance we will have to develop a long-term relationship. It is our goal to help you enjoy the benefits of good health for the rest of your life. We consider it a major part of our responsibility to help our patients understand and plan for their oral health needs in the years ahead, to fully understand the meaning of prevention and to learn the procedures and discipline necessary to be free of dental decay and gum disease.

We strive to be perceptive and sensitive to the feelings of our patients at all times, and to be empathetic to their physical and emotional discomforts. Above all, we strive to give each patient the best quality dental care in every possible respect, constantly updating our knowledge and methodology. Before any treatment is undertaken, we consult our patients so that there is full understanding of the need, the procedures by which treatment will be rendered, and of the possible penalties to oral health if the necessary dentistry is not completed.

The enclosed welcome package includes forms that request information about your personal, dental and medical history, as well as your expectations of our office. Please be sure to complete both sides of these forms and return them in the self-addressed stamped envelope. If you have dental insurance, please provide us with a completed claim form for our records. Information about our office and what to expect on your fist visit is also included. Our objectives are high quality and preventative dentistry. By having all this information available to us when you come in, we hope we can make your first visit, and all those that come after, more pleasant and productive.

We suggest that you take the time to fill this out when you are not rushed and can think about what your goals are for your mouth, what has helped you to reach your goals for oral health or a beautiful smile up to this time. Of course, all your personal information will be kept completely confidential. If you have any questions or problems that come up before your scheduled appointment, don't hesitate to call or visit our website, www.TampaSmiles.com. Please know, if you are in pain, we will always see you right away.

We want our patients to be our friends. If you have any questions, please feel free to call us. If an earlier opening comes available, we will be happy to give you a call to see if that will work. We reserve this time just for you so that you will have our full attention. If there is any reason you will not be able to make this appointment, please give us at least 24 hours notice. We look forward to our visit with you.

Sincerely,
Dr. John L. Redd & Staff

907 West Platt Street • Tampa, Florida 33606 • 813.253.0209 • www.TampaSmiles.com

Personal Information

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. The information gathered on the next several pages will allow us to serve you better. Thank you in advance for taking the time to complete them before you come in for your examination.

Name _____

I like to be called _____

Social Security Number _____ Date of Birth _____

Home Address _____City/State/Zip _____

Employer _____ Occupation _____

Employer's Address _____City/State/Zip _____

Marital Status: Single Married Widowed Divorced

Spouse's Name _____

Who can we thank for referring you to our office? _____

Special interests or hobbies _____

Musical likes or dislikes _____

Telephone Information

Home Phone _____Work Phone _____

Pager or Cell Phone_____E-mail Address _____

When is the best time to call? _____ and Where? _____

In case of emergency, is there someone we can call?

Name _____Phone Number _____

Insurance Information

Dental Insurance Company _____Phone _____

Group Number_____ Policy Number _____

Insurance Company Address _____City/State/Zip _____

If the insurance coverage is not in your name, please complete the following information for the insured

Employer _____Social Security Number _____

Work Address _____ City/State/Zip _____

Phone Number _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please explain: _____
Do you take, or have you taken antibiotics before a dental appointment? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
Have you ever been diagnosed with oral cancer? ☐ Yes ☐ No

WOMEN: Are you:
☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking Contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphalaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limba
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsilitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE _____

Dental History

How can we help you? _____

When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? ..... Yes ☐ No ☐

If so, explain _____

Do you avoid brushing any part of your mouth because of pain? ..... Yes ☐ No ☐

If yes, what part? ..... Yes ☐ No ☐

Do you feel twinges of pain when your teeth come in contact with (Circle) HOT COLD SWEET SOUR

Do you chew on only one side of your mouth? ..... Yes ☐ No ☐

If yes, explain _____

On a scale of 1-10, 10 being the highest, what priority do you give your teeth? _____

On a scale of 1-10, 10 being the highest, how would you rate the health of your mouth? _____

What brings you down from a 10? _____

How often do you brush your teeth? _____

How often do you floss? _____

Do your gums bleed while brushing? ..... Yes ☐ No ☐

Do your gums bleed while flossing? ..... Yes ☐ No ☐

Does the floss tear or break when flossing any of your teeth? ..... Yes ☐ No ☐

Do you feel pain to any of your teeth when brushing or flossing them? ..... Yes ☐ No ☐

Do you have pain in any part of your mouth or in any tooth while biting or chewing? ..... Yes ☐ No ☐

Do your gums feel tender or swollen? ..... Yes ☐ No ☐

Do you usually have many cavities? ..... Yes ☐ No ☐

Do you lose or break fillings? ..... Yes ☐ No ☐

Do you gag easily? ..... Yes ☐ No ☐

Do you feel your bite is off; bad bite? ..... Yes ☐ No ☐

Does food catch between your teeth? ..... Yes ☐ No ☐

Do you eat a piece of candy or chocolate every day? ..... Yes ☐ No ☐

Do you drink regular soft drinks or chew regular gum every day? ..... Yes ☐ No ☐

Do you have a regular exercise program? ..... Yes ☐ No ☐

Are you happy with your past dentistry? ..... Yes ☐ No ☐

Are you familiar with the term “comprehensive care?” ..... Yes ☐ No ☐

Can you chew properly? ..... Yes ☐ No ☐

Are you happy with the appearance of your teeth? ..... Yes ☐ No ☐

Have you ever had problems with your TMJ? ..... Yes ☐ No ☐

Are you in the habit of biting your nails or any other hard object? ..... Yes ☐ No ☐

Do your jaws ever feel tired when you wake up, talk or chew a lot? ..... Yes ☐ No ☐

Do you ever have pain, clicking, popping, or grating sounds from your jaw joint? ..... Yes ☐ No ☐

Does it hurt when you open wide or take a big bite? ..... Yes ☐ No ☐

Does your jaw ever lock or go out, i.e. get stuck open or closed? ..... Yes ☐ No ☐

Does your jaw make noise so that it bothers you or others? ..... Yes ☐ No ☐

Do you ever have ringing or pain in your ears? ..... Yes ☐ No ☐

Do you have chronic earaches? ..... Yes ☐ No ☐

Do you grind your teeth during the day or night? ..... Yes ☐ No ☐

Have you ever had orthodontics (braces)? ..... Yes ☐ No ☐

Have you ever had periodontal therapy (gum surgery)? ..... Yes ☐ No ☐

Have you ever had endodontic therapy (root canal)? ..... Yes ☐ No ☐

Have you ever been treated by an oral surgeon? ..... Yes ☐ No ☐

What is the one thing that you liked least about any former dentist or the office? _____

What is the one thing that you liked best about any former dentist or the office? _____

If there is a need to cancel an appointment, please give us 48-hours notice so another patient may receive care.

This information was given by: _____

As it relates to my medical history, all of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medicines change, I will inform Dr. Redd or his staff at my next dental appointment without fail. (Insurance patients only: I authorize release of any information relating to dental insurance claims.) I understand that I am responsible for all costs of dental treatment and that before credit is extended a credit report will be obtained.

Signature: _____ ***Thank You!***

Dental History

These things are important to me about my dental health:

_____

Former Dentist's Name _____ City _____

Please Circle One:

1. My mouth is: (a) very comfortable.
(b) moderately comfortable.
(c) uncomfortable.

2. I: (a) think the appearance of my mouth is excellent.
(b) think the appearance of my mouth is adequate.
(c) wish I could change the appearance of my mouth.

3. I: (a) want to save my teeth at all costs.
(b) prefer to keep my teeth if cost and time are reasonable.
(c) expect to someday lose my teeth and have dentures.

4. I: (a) have set goals to achieve optimum oral health with a previous dentist.
(b) want to set goals to achieve optimum oral health.
(c) am not very interested in setting personal goals to achieve optimum oral health.

5. I: (a) have followed the recommendations for optimum dental health given by my dentist.
(b) have not done what dentists recommended I do with my mouth.
(c) usually only go to the dentist for emergencies.

6. I think I: (a) am in EXCELLENT oral health.
(b) am in GOOD oral health.
(c) am in POOR oral health.

7. I desire: (a) excellent oral health.
(b) average or good oral health.
(c) crisis care only.

8. What are some questions about dentistry and your oral health that you have never had adequately answered?

_____

_____

As it relates to my medical history, all of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medicines change, I will inform Dr. Redd or his staff at my next dental appointment without fail. (Insurance patients only: I authorize release of any information relating to dental insurance claims.) I understand that I am responsible for all costs of dental treatment and that before credit is extended a credit report will be obtained.

Signature: _____ ***Thank You!***

Appointment Policies

Dr. Redd prefers to reserve a specific time in his schedule for each patient's dental treatment. By scheduling this way, Dr. Redd can focus and give the best dental treatment to each patient. To insure that our patients can be seen at their scheduled time, the following appointment policies have been established.

> Dr. Redd requires a minimum of forty-eight (48) hours notice to reschedule any appointment.

If a patient has a problem with scheduling, they may prefer to be scheduled from the Doctor's Priority Reservation List. The Priority Reservation List is a list of patients that need an appointment as soon as possible or that have specific preferences and/or needs. Patients on this list are offered the appointments that other patients give up with proper notice. The patients from the Priority Reservation List are contacted when each of these appointments become available and are given an opportunity to reserve that time. The patient on the Priority Reservation List may choose to take the current appointment being offered or stay on the Priority Reservation List until another appointment better suiting their needs become available.

Arriving late for an appointment

If the patient arrives late for an appointment, the front office staff will contact the Doctor to see that there will be sufficient time to complete the dental treatment. If the Doctor believes that the treatment cannot be completed within the patient's remaining allotted time, the treatment will be rescheduled for another time so the next patient that is scheduled will not have to wait.

_____ _____

Patient's (Guardian) Signature Date

Financial Policy

Our experience has shown that many questions and/or problems about our financial policies can be avoided by understanding our office policies.

Our office policy requires that payment is due in full at the time your dental treatment is rendered. As a courtesy to our patients with dental insurance, Dr. Redd may agree to accept a patient's insurance assignment. If our office staff is able to determine the expected coverage of your insurance plan, our office will submit your claim to your insurance company as a courtesy to you. We will wait up to 60 (sixty) days for the insurance payment to be received and applied to your account. The patient or person responsible for the account must pay any deductible, co-payment or difference between the insurance company's fees and the office fees at the time the services are rendered.

If for any reason your insurance company does not pay the insurance claim or does not pay the full amount of the expected benefit within 60 (sixty) days from the date of service, the balance will be transferred from an insurance balance to a personal balance. A statement will be sent to the person responsible for the account and payment will be expected within 10 (ten) days.

An important issue to remember is that the doctor will prescribe dental treatment on the basis of their patient's need not on the dental treatment the insurance will or will not cover.

The first issue with our financial policy is to understand that the balance due on your account is not your insurance company's, but your balance. It is your responsibility and your benefits provider at work to know your insurance policy. It is YOUR responsibility to be aware of any deductibles, yearly maximums, co-payments or non-covered services.

The second issue is the insurance coverage quoted to you is just an estimate of the services you will receive. Payment by your insurance company is not guaranteed from the pretreatment estimate.

The doctor and staff are committed to work with our patients to help them secure the maximum dental benefits to which they are entitled. If you have any questions concerning any of this information, please do not hesitate to contact our office to assist you.

_____ _____

Patient's (Guardian) Signature Date

Notice of Privacy Practices

John L. Redd II, DMD PA
907 West Platt Street
Tampa, FL 33606

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. Our doctors, clinical staff, Business Associates (outside contractors we hire), employees, and other office personnel follow the policies and procedures set forth in this notice. If your regular doctor is unavailable to assist you (e.g. illness, on-call coverage, vacation, etc.), we may provide you with the name of another health-care provider outside our practice for you to consult with by telephone. If we do so, that provider will follow the policies and procedures set forth in this notice or those established for his or her practice, so long as they substantially conform to those of our practice.

This notice takes effect April 14, 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 anytime, 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 policies, we will change this Notice to 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 our privacy officer.

Uses and Disclosures of Health Information

Our staff will not use or access your protected health information (PHI) unless it is necessary to do their jobs. Also, we disclose to others outside out staff only as much of your protected health information as is necessary to accomplish the recipient's lawful purposes.

You will be asked to sign a consent form authorizing us to use and disclosure personal health information only for the following purposes, as defined under the Health Insurance Portability and Accountability Act (HIPPA) of 1996:

- Treatment means the provision, coordination, or management of health care and related services by one or more health-care providers, including the coordination of management of health care with a third party; consultation between health-care providers relating to a patient; or the referral of a patient for health care from one health-care provider to another. We may call prescriptions to your pharmacy and/or disclose needed information to your family or others so that they may assist you with home care.
- Payment means obtaining reimbursement for the provision of health care; determination of eligibility of coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies. An example of this would be submitting your bill for health-care services to your insurance company.
- Health Care Operations are any activity related to covered functions in which we participate in the function of our office, such as conducting quality assessment activities; protocol development; case manage-

ment and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. To improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail, or e-mail or otherwise remind you of scheduled appointments; we may leave messages with whoever answers your telephone (but we will not give out detailed protected health information).

We may, without prior consent use or disclose your personal health information to carry out treatment, payment, or health care operations:

- To family members, friends, and others, but only if you verbally give permission; we give you an opportunity to object and you do not; we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (e.g., you bring someone with you into the operating room or your exam room during treatment or into the conference area when we are discussing your protected health information); we reasonably infer that it is in your best interest (e.g., to allow someone to pick up your records because they know you were our patient and you asked them in writing with your signature to do so).
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practical after the delivery of such treatment. If we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly and for inferred from circumstances.
- When necessary for public health reasons (e.g., prevention or control of disease, reporting information such as adverse reactions to anesthesia, suspected abuse or domestic violence).
- For judicial and administrative proceedings and law enforcement purposes.
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree or prohibit or restrict the use or disclosure.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to the revocation notice.

Patient Rights

Under HIPPA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- 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 practically do so. (You must make your request in writing to obtain access to your healthcare information. You may obtain a form to request access by contacting our Privacy Officer.) If you request copies, we may charge you a fee not to exceed Florida law to recover our costs (including postage, supplies and staff time as applicable, but excluding staff time for search and retrieval). If you request an alternative format, we will charge you a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or explanation of your health information for a fee.
- 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.)

- 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).
- You have the right to request that we communicate with you in a different way or at a different place by submitting a written request. (You may obtain a form for alternative communication by contacting our Privacy Officer.) You must tell us the alternative means or location you want us to use and explain to our satisfaction how payments to us will be made if we communicate with you as you requested.
- You have the right to receive a list of instances in which our business associates or we disclosed your health information for purposes other than treatment, payment, or health care operations. This list will include all instances for the last six years, but not before April 14, 2003. If you request this accounting more than once in a twelve-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Incidental Disclosure

We will take reasonable administrative, technical, and security safeguards to ensure the privacy of your PHI when we use or disclose it (e.g., we require employees to talk softly when discussing PHI with you, we use computer passwords and change them periodically, we allow access to areas where PHI is stored or filed only when we are present to supervise and prevent unauthorized access).

Business Associates

Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from re-disclosing it unless required to do so by law or you give prior express written consent to the re-disclosure. Nothing in our Business Associate agreement will allow our Business Associates to violate this re-disclosure prohibition.

Practice Transition

If we sell our practice, our patient records (including but not limited to your PHI) may be disclosed and physical custody may be transferred to the purchasing doctor, but only in accordance with the law. The doctor who is the new records owner will be solely responsible for ensuring privacy of your PHI after the transfer and you agree that we will have no responsibility for (or duty associated with) transferred records. If all the owners of our practice die, our patient records (including but not limited to your PHI) must be transferred to another doctor within ninety days to comply with Florida Board of Dentistry rules. Before we transfer records in either of these two situations, our privacy officer will obtain a Business Associate agreement from the purchaser.

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 by contacting our Privacy Officer. You may also 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.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receipt of a copy of the currently effective *Notice of Privacy Practices* for the office of Dr. John L. Redd II on this _____ day of _____, 20___.
A copy of this signed, dated acknowledgement shall be as effective as the original.

Patient Name Printed: _____

Patient Signature: _____

If you are the legal representative of the patient, please describe your authority

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PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health-care providers involved in my treatment);
- Obtaining payment from third party payers (e.g., my insurance company);
- The day-to-day health care operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Date of Consent: _____

Patient's Name Printed: _____

Patient's Signature: _____