Welcome to Hilton Head Oral and Maxillofacial Surgery

Date_____

Name_____ Age_____ Birth Date_____ Sex_____
Last First M.I.

Mr._____Mrs._____Ms._____Dr._____

Social Security # _____ Driver's License # _____

Home Address_____City_____ State_____ Zip _____

Home Phone _____ Work Phone_____ Email _____

Employer_____ Occupation_____ Marital Status_____

Whom may we thank for referring you to us? _____ Phone_____

Who is your dentist?_____ Phone _____

Who is your physician? _____ Phone _____

Primary Dental Insurance:_____ Name of subscriber: _____DOB_____

Relationship to patient _____

Employer_____ Group #_____ ID #_____ SS #_____

Seconday Dental Insurance:_____ Name of subscriber: _____DOB_____

Relationship to patient _____

Employer_____ Group #_____ ID #_____ SS #_____

Primary Medical Insurance:_____ Name of subscriber: _____DOB_____

Relationship to patient _____

Employer_____ Group #_____ ID #_____SS #_____

Secondary Medical Insurance:_____ Name of subscriber: _____DOB_____

Relationship to patient _____

Employer_____ Group #_____ ID #_____SS #_____

Who should we contact in case of emergency?

Name_____ Phone_____

Who is financially responsible for your bill? (If different than patient)

Name_____ DOB_____ Phone _____
Last First M.I.

Relationship to patient_____ Employer_____ Work Phone_____

Address_____ City_____ State_____ Zip_____

SS#_____ Driver's Lic. # _____

Patient's Name | Date of Birth | Height | Weight | Date

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis? ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - P. Radiation (X-ray) treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - R. Sinus or Nasal problems? ..... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) ? ..... Y N
   - J. Have you ever been advised <u>not</u> to take a medication? ..... Y N
   - K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

     _____
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber products? ..... Y N
   - G. Metal of any kind? ..... Y N
   - H. Chemicals or jewelry (rash or sensitivity)? ..... Y N
   - I. Food products? ..... Y N
   - J. Other allergies or reactions? Please list ..... Y N

     _____

     _____
9. Do you smoke or chew Tobacco? ..... Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
11. Have you had any serious problems associated with any previous dental treatment? ..... Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
14. Do you wish to talk to the doctor privately about anything? ..... Y N
15. Have you ever had a bone density scan? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or <u>**is there any chance**</u> you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my surgeon in providing the best care possible. I have had the opportunity to discuss my Health History with my surgeon. I authorize my surgeon and his/her designated staff to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Date | Signature of Person Completing Health History | Doctor's Initials

Hilton Head Oral & Maxillofacial Surgery

FINANCIAL POLICY

Thank you for choosing us as your oral & maxillofacial surgery provider. We are committed to your visit with us being pleasant and successful. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Patient With Insurance - I understand my insurance may only pay a portion of the cost of my treatment. My portion is due at the time of treatment. The amount collected at the time of treatment is only an *estimate*. This estimate is based on information received over the telephone or online from the insurance company. This is not a guarantee of benefit or payment. If the insurance company pays less than anticipated, or denies my claim, I will receive a statement and it will be my responsibility to pay the remaining amount due. In the event my insurance company does not make payment within 90 days, I will be notified. If payment is not received within 120 days, I understand that I am responsible for the remaining balance. If the insurance company pays more, I will be mailed a refund. As a courtesy, the office will submit a claim on my behalf, but I am ultimately responsible for the total amount due.

Patient Without Insurance - I understand payment in full is expected at the time of treatment.

Methods of Payment - Cash, Check, Visa, Mastercard, American Express, Discover, and Care Credit.

Returned Checks - I understand a $35.00 fee will be added to my account balance for any returned checks.

Service Fee - I agree that a max of 30% collection fee will be added to my balance owed should my account be forwarded to a collection agency for recovery. I understand that any attorney and court fees incurred in the collection process will also be guaranteed by me.

Minor Patient - A patient age seventeen or younger is considered a minor. An adult or guardian must accompany the patient for treatment. The adult accompanying the patient *and* the parent(s) are financially responsible for the account. In the event the parents are divorced, the settlement must be resolved between the parents. For unaccompanied minors, non-emergency treatment will be denied.

Authorization to Release Information - I hereby authorize Hilton Head Oral & Maxillofacial Surgery to release information acquired in the course of examination and/or treatment for insurance claims processing and/or legal purposes.

You are entitled to a copy of this contract for your records

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Witness (Staff Member) Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization. **You have the right to request an alternative means of confidential communication** – This means you have the right to ask us to contact you about medical matters using an alternative method, and to a destination designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the home address/ telephone; email; cellphone; work phone that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office. **You have the right to receive a privacy breach notice** - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment. **Special Notices** - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organizati to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it i in your best interest based on our professional judgment. We n use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. I you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, usin professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary v be disclosed.

Other Permitted and Required Uses and Disclosures - We a also permitted to use or disclose your PHI without your writte authorization for the following purposes: as required by law; fi public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administratic requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facil and if requested by the Department of Health and Human Services in order to investigate or determine our compliance w the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a compl with us by notifying the Privacy Manager:

Hilton Head Oral & Maxillofacial Surgery, Hilton Head, SC

I have had full opportunity to read and consider the contents o this Consent form, and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heal care operations.

Signature:_____

Date: _____

If this consent is signed by personal representative complete the following:

Representative:_____

Patient Relationship:_____

HILTON HEAD ORAL & MAXILLOFACIAL SURGERY

Thank you for choosing us as your Oral & Maxillofacial Surgery provider. We are committed to your visit with us being pleasant and successful. The following is a statement of our CANCELLATION POLICY which we require you to read and sign prior to any treatment.

CANCELLATION POLICY – Cancellations or a No-Show appointment within a 24-hour period may be subject to a $50.00 cancellation fee.

If you have two cancellations and/or no shows, it will be more difficult for scheduling.

_____ _____

Signature of Patient Or Responsible Party Date

_____ _____

Witness (Staff Member) Date

SR:sr – f drive