**Oral-Facial & Implant Surgery, P.A.**

**Stephen F. Anderson, D.D.S.**

**Jay C. Cagata, D.M.D., M.D.**

# PATIENT HEALTH HISTORY

NAME_____ DATE OF BIRTH_____AGE_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

HOME ADDRESS_____ CITY_____ STATE_____ ZIP_____

PATIENT'S GENERAL DENTIST_____ PATIENT'S PHYSICIAN_____

REFERRED BY_____ REASON FOR VISIT_____

**PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES OR NO, AND UNDERLINE EACH CONDITION FOR ANY "YES" ANSWERS.**

1. Are you now under a physician's care for a particular problem? If so, for what? YES NO
   _____
2. Have you had any operations, hospitalizations, or serious illnesses? If so, describe. YES NO
   _____
   _____
   _____
3. Have you had any adverse effects from surgery, dental treatment, or anesthesia? YES NO
4. Do you have, or have you ever had:
   a. Rheumatic fever or rheumatic heart disease? YES NO
   b. Congenital heart disease? YES NO
   c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, chest pain, high blood pressure, stroke, palpitations, heart surgery, pacemaker)? YES NO
   d. Lung or airway disease (asthma, emphysema, bronchitis, pneumonia, tuberculosis, shortness of breath, severe or chronic cough, waking and gasping for air at night)? YES NO
   e. Seizures, convulsions, epilepsy, fainting spells, psychiatric treatment, dizziness, nervousness, nervous breakdown? YES NO
   f. Bleeding disorder, anemia, bleeding tendency, blood transfusion, easy bruising? YES NO
   g. Liver disease (jaundice, hepatitis)? YES NO
   h. Kidney disease? YES NO
   i. Diabetes? YES NO
   j. Thyroid disease? YES NO
   k. Arthritis? YES NO
   l. Stomach ulcers or colitis? YES NO
   m. Glaucoma? YES NO
   n. Implants placed anywhere in your body (heart, valve, hip, knee)? YES NO
   o. Radiation (x-ray) treatment for cancer? YES NO
   p. Clicking or popping of the jaw joint, pain near the ear, difficulty opening the mouth, grinding or clenching of teeth? YES NO
   q. Sinus or nasal problems? YES NO
   r. Any disease, drugs, or transplant operation that has depressed your immune system? YES NO
   s. Recurrent infections of any kind? YES NO
5. Are you taking any medications, pills, or drugs? YES NO
   If yes, please list:_____
   _____
   _____
   _____
   _____
6. Have you ever been given any drugs or treatments to maintain or increase your bone density (eg. for osteoporosis or bone cancer)? YES NO
7. Are you allergic to or have you had a bad reaction to:
   a. Medications or drugs? YES NO
   If so, please list:_____
   _____
   _____
   _____
   _____
   b. Latex or rubber products? YES NO
8. Do you smoke or chew tobacco? YES NO
   If yes, how much per day?_____
   For how long?_____
9. Do you drink alcohol? YES NO
   If yes, how often?_____
10. Do you have any other disease, condition. or problem not listed above that you think the doctor should know about? YES NO
    If yes, please describe.
    _____
    _____

FOR WOMEN ONLY

1. If you are using oral contraceptives, it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control during and after the course of antibiotics or other medications. Please consult with you physician for further guidance.
2. If you are pregnant or possibly pregnant, or trying to become pregnant, surgery, anesthetics, or any medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance that you are pregnant.

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I/WE, the undersigned, do hereby fully authorize Dr. Anderson and/or Dr. Cagata to perform an examination, and obtain x-rays as deemed necessary.

SIGNATURE_____ SOCIAL SECURITY NUMBER _____-_____-_____ DATE_____

**ORAL-FACIAL & IMPLANT SURGERY, P.A.**
**FINANCIAL AND INSURANCE POLICY**

Please determine your insurance status.

A. No insurance — You will be asked to pay in full the day of services rendered.
B. If your insurance pays you directly, you will be asked to pay us in full today.
C. **PPO/ HMO/ Managed Care** **Medica**l or **Dental**

1. Your insurance company provides you with a list of participating physicians. You will be asked to pay according to your contract, as long as we are contracted providers for your insurance.

2. If we are not contracted providers for your insurance, we will call the insurance company and determine your benefits.

D. Traditional/ Indemnity Insurance (not a HMO or PPO) **Medical** or **Dental**
Your insurance company pays the same benefit regardless of the physician you choose. There is no list of participating providers.

1. You will be asked to pay any unmet portion of your deductible plus 50% of the remaining charges provided that:
   -you have enough remaining benefits to cover the charges
   -the policy is at least 80/20%
   -the procedure codes are covered

2. You may pay your bill in full, and we will submit a claim for you or we can give you a receipt with complete filing instructions and you can file to your insurance company yourself. The advantage of filing the claim yourself is that the insurance company usually sends the check directly to you.

E. **Dental Discount Plans** - This type of plan offers you a discount at the speciallst's office.

Our office can submit a written predetermination (Pre-D) of benefits. This is a letter to your insurance company requesting written verification of the amount they will pay. This may result in delay of treatment.

Even though we may allow you to pay less than 100% of your charges at the time of service, this does not relieve you from your responsibility to pay these charges. It is our office policy to try to help you in any way we can to obtain reimbursement from your insurance company.

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**I understand that if my insurance company has not paid the balance of my account within 90 days of the date of service, it is my responsibility to pay the balance in full. If this balance is not paid within 90 days, 1% interest per month will be added. I agree to reimburse Oral-Facial and Implant Surgery the fees of any collection agency, which may be based on a percentage a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, incurred in such collection efforts.**

_____ _____
Patient's / Patient Guardian's Signature Date

**I authorize the release of any medical or other information necessary to process this claim.**

_____ _____
Patient's / Patient Guardian's Signature Date

**I authorize payment of medical benefits to Oral-Facial and Implant Surgery for services rendered.**

_____ _____
Patient's / Patient Guardian's Signature Date

**I have been notified that today's services are not covered by Medicare. I understand that I am responsible for these charges.**

_____ _____
Patient's / Patient Guardian's Signature Date

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**PERSON RESPONSIBLE FOR ACCOUNT**

Name _____Home Phone #_____

Home Address_____

Employer_____ Position_____ Work Phone #_____

Social Security # _____Spouse's Employer_____

**EMERGENCY CONTACT**

Name of person to contact in the event of an emergency _____Relationship_____

Home phone _____Cell phone_____ Work phone_____

# Notice of Privacy Practices for Protected Health Information

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

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

**Example of uses of your health information for treatment purposes:**
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

**Example of use of your health information for payment purposes:**
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

**Example of Use of Your Information for Health Care Operations:**
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

**Your Health Information Rights**
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Ask someone who has medical power of attorney or your legal guardian, to exercise your rights and make choices about your health information.
- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Request you be allowed to inspect your health record and billing record - you may exercise this right by delivering the request in writing to our office;
- Obtain a copy of your paper or electronic record.
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Elect to opt out of receiving further communications to raise funds for the practice.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact **Jean Murphy,** in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

**Our Responsibilities**
The practice is required to:
- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you;
- We will never share your information (for marketing purposes, sale of your information, sharing of psychotherapy notes) without your written permission:, and
- Notify you if you are affected by a breach of unsecured PHI

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

**To Request Information or File a Complaint**
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Jean Murphy, practice manager, (239) 275-0550.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Jean Murphy**. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

**Other Disclosures and Uses**

**Notification**
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

**Communication with Family**
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

**Food and Drug Administration (FDA)**
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

**Workers Compensation**
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

**Public Health**
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Abuse & Neglect**
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

**Correctional Institutions**
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.
**Law Enforcement**
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

**Health Oversight**
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

**Judicial/Administrative Proceedings**
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

**Other Uses**
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

**Website**
If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: November 25, 2013

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____
Name Date

**OPTIONAL/ADDITIONAL Uses and Disclosures**

The following are segments of the Notice of Privacy Practices that may not be applicable to a dental or OMS practice. If any are applicable and your Notice of Privacy would need to incorporate them, we have provided model language. An example would be: If your practice participates with drug research, then you would need to include the first item listed below in your Notice of Privacy Practices.

**Research**
- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Disaster Relief**
- We may use and disclose your protected health information to assist in disaster relief efforts.

**Funeral Directors/Coroners**
- We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

**Organ Procurement Organizations**
- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Marketing**
- We may contact you to provide you with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

**Fund Raising**
- We may contact you as part of a fund raising effort.

**For Specialized Governmental Functions**
- We may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.