Patient Information ***Oral Surgery of Tidewater***

First Name_____ **MI**_____ **Last Name**_____**Today's Date**_____
Address_____Apt#____City_____State_____Zip_____
Home#_____Cell#_____E-Mail_____
Employer_____ Employer Phone#_____Work Status FT ☐ PT ☐
Date of Birth____/____/_____Age____ Sex M ☐F ☐ Social Security#_____Marital Status_____
Emergency Contact_____ Relation_____Phone#_____
Referring Dentist_____ MedicalDoctor_____
Student Status FT ☐ PT ☐ School Name_____
How did you hear about us? Referring Dentist/Doctor ☐ Website ☐ Yelp ☐ Facebook ☐ TV ☐
Internet Search ☐ Family/Friend ☐ Name_____

Responsible Party (If other than patient or under 18)

First Name_____ MI_____ Last Name_____Patient Relation_____
Address_____Apt#____City_____State_____Zip_____
Home#_____Cell#_____E-Mail_____
Employer_____ Employer Phone#_____ _____ Work Status FT ☐ PT ☐
Date of Birth____/____/_____Age____ Sex M☐ F☐ Social Security#_____ Marital Status_____

Primary Dental Ins_____ Member ID#_____ Group#_____
Subscriber Name_____ Patient Relation_____
Address_____Apt#____City_____Zip_____
Home#_____Cell#_____Work#_____
Date of Birth____/____/_____ Age____ Sex M ☐ F ☐ Social Security#_____

Secondary Dental Ins_____Member ID#_____ Group#_____
Subscriber Name_____ Patient Relation_____
Address_____Apt#____City_____Zip_____
Home#_____Cell#_____Work#_____
Date of Birth____/____/_____ Age____ Sex M ☐ F ☐ Social Security#_____

Primary Medical Ins_____Member ID#_____ Group#_____
Subscriber Name_____ Patient Relation_____
Address_____Apt#____City_____Zip_____
Home#_____Cell#_____Work#_____
Date of Birth____/____/_____ Age____ Sex M ☐ F ☐ Social Security#_____

Secondary Medical Ins _____ Member ID#_____ Group#_____
Subscriber Name_____ Patient Relation_____
Address_____Apt#____City_____Zip_____
Home#_____Cell#_____Work#_____
Date of Birth____/____/_____ Age____ Sex M ☐ F ☐ Social Security#_____

Until I show proof of insurance, that is, a card or a completed claim form, I will be considered a cash patient. I understand that I am responsible for payment of all incurred fees not covered by my insurance plan. If the claim is denied because I neglected to bring a referral from my PCP or because the procedure is not a covered benefit under my policy I am still obligated to remit the remaining balance. There is a $50 broken appointment fee for every 30-minute of an appointment not cancelled within 24 hours. All accounts 60days past due will accrue a service charge at the rate of 18%APR. In addition, should my account become delinquent, it is my understanding that I will also be responsible for all collections costs (50%) and attorney fees (40%). There is a $35 charge for all returned checks.

Signature of Responsible Party **Print Name of Responsible Party** **Date**

Medical History **Oral Surgery of Tidewater**

Patient Name_____ Date of Birth_____ ID#_____
(Office Use)

Height_____ Weight_____ Sex F M Occupation_____

Please answer the following to the best of your ability: **Please Circle where applicable*

Reason for today's visit / Chief Complaint _____

Are you currently experiencing pain? Yes No
If yes, on a scale of zero to ten, how severe is your pain? **0 1 2 3 4 5 6 7 8 9 10**
(No Pain) (Severe Pain)

Are you under care of a physician? Yes No
If yes, name of Physician(s)**:**_____

Are you in good health? Yes No
Do you exercise? Yes No
Can you go up two flights of stairs without shortness of breath or chest pain Yes No

Substance History:

Tobacco**:** Yes Never Quit Passive Type: Cigarettes Pipe Cigars Chew
If yes, for how long _____ If quit, when _____

Drink Alcohol? Yes No History of Alcohol Abuse: Yes No
Do Recreational Drugs? Yes No History of Drug Abuse: Yes No

Have you had any serious trouble associated with previous dental treatment/ surgery? Yes No
Are you wearing removable dental appliances? Yes No
Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? Yes No
Any disease, drug or transplant operation that has depressed your immune system? Yes No
Are you taking or have you ever taken medications for osteoporosis or chemotherapy for multiple myeloma or other cancers (Prolia, Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? Yes No
If yes, what drug? _____
Do you have any beliefs that might alter the care we give you? Yes No
Do you wish to talk to the doctor privately about anything? Yes No
List any special considerations or anything else you would like us to know: (example: hard of hearing?)

_____

_____

Women Only:
Are you pregnant or trying to become pregnant? Yes No
Are you nursing? Yes No
Do you have problems associated with your menstrual period? Yes No
Are you taking oral contraceptive? Yes No
Are you on Hormonal Therapy? Yes No

Patient Name_____ Date of Birth_____ ID#_____
(Office Use)

Check all conditions that apply, add any that pertain to you not listed or check none.

Cardiovascular

___ **NONE**
___Heart Failure
___Phlebitis
___Blood Clot
___Endocarditis
___Vascular Disease
___Heart Disease
___ Other_____
___Pacemaker
___ High Blood Pressure
___Rheumatic Fever
___Irregular Heartbeat
___Heart Attack
___Heart Murmur
___Heart Valve Replacement
___Damaged Heart Valve
___Chest Pain (Angina)

Pulmonary

___**NONE**
___Lung Cancer
___COPD
___Embolism
___Shortness of Breath
___Other_____
___Asthma
___ Emphysema
___Tuberculosis

GI/Endocrine

___**NONE**
___Hiatal Hernia
___Hepatitis/Jaundice
___Liver Disease
___Heartburn
___Other_____
___Diabetes
___Thyroid Disease/Trouble
___Acid Reflux/Stomach Ulcers

Renal/GU

___**NONE**
___Renal Failure
___Difficulty Urinating
___Other_____
___Dialysis

Musculoskeletal

___**NONE**
___Muscle Weakness
___Other_____
___Arthritis
___Osteoporosis/Osteopenia

Hematological/Cancer

___**NONE**
___Cancer
___Sickle Cell
___MRSA
___Other_____
___Anemia/Blood Disorder
___Prior Transfusions
___HIV/AIDS
___Bleeding Tendency
___Radiation/Chemo

Neuro/Psych:

___**NONE**
___Parkinson's
___ Spinal Injury
___Headaches
___Head Trauma/Injury
___Mental Disability
___Depression/Anxiety
___Other_____
___Stroke
___ Convulsions/Epilepsy

Airway & Neck

___**NONE**
___Difficulty Swallowing
___TMJ/TMD
___Other_____
___Immune System Problems
___Sleep Apnea
___Sinus Problems/Hay Fever
___Pain/Click in Jaw

Anesthesia History

___**NONE**
___Anesthesia Reaction
___Difficulty to Intubate
___Post-Op Nausea/Vomiting
___Other_____
___Family History
___Malignant Hyperthermia

Surgical History

___**NONE**
___Cardiac Stent
___Heart Bypass
___Amputation
___Other_____

Please list allergies to drugs, food, latex and any other substances. (Include the reactions):

_____

Patient Name_____ Date of Birth_____ID#_____
(Office Use)

Please list all of your medications, reason for each, and dosage. (Include any over the counter medications)

	Prescribed Medications, Supplements, Herbal Remedies	Reason for Medication	Dosages
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

I have read and understand the above questions. Any questions I had about this form have been answered and I understand the answers. I understand that it is my responsibility to fill out the form accurately and as completely as I can.

Patient's Signature_____ Date_____

Doctor's Signature_____Date_____

Ford & Guter, D.D.S, Ltd.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent.

Below is a list of ways the office may contact you. Checking a box will give us permission to leave, as thorough of a message as needed, from your dental office. This will include, but not be limited to, appointment day, time, and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

Please check all that apply, and write in appropriate information needed for contact.

___Personal Cell_____ ___Home Phone_____
___Work Email_____ ___Personal Email_____
___Mail to Work_____ ___Mail to Home_____
___Emergency Contact_____ ___Other_____

List the names of those who may have access to your dental/medical chart information: State what part of your chart: Financial, Treatment and/or Health History, is allowed to be disclosed or copied

_____Full Access/Partial Access _____Full Access/Partial Access

Post operative care escort if different from above:_____ Number:_____

_____Patient gives office permission to forward any verified contact information and PHI (Protected Health Information) to patient's specialists. Office may discuss pertinent chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. Under HIPAA regulations, healthcare providers do not need permission for Public Policy Purposes, refer to Notice of Privacy Practice. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Example: Dental Labs. Patient understands if permission is not granted, USPS (Federally Secured) is the only means of communication with those involved in patient's case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment cost. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name _____ **Date**_____

Print Legal Guardian's Name_____ **Date**_____

Signature of Patient or Legal Guardian_____ **Date**_____

_____Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Witness: _____ Printed Name_____ Date_____

Notice of Rights for Secure Communication and Waiver of Those Rights

Federal law requires this practice to use secure/encrypted methods when e-mailing patients. However, many patients do not participate in secure e-mail platforms or find encrypted e-mail undesirable. And at this time, the practice has limited ability to offer secure/encrypted method to communicate electronically with patients.
But this practice still takes patient confidentiality and legal compliance *very seriously*. We will not send a patient electronic communication that is not secure/encrypted, unless the patient authorizes the practice to do so.
Please put an "x" next to the statement you agree to. Choose only one statement.

___For electronic communications that include my private information (such as name, date of birth, health condition, diagnosis, or billing/financial information) I wish to receive *only* secure/encrypted electronic communications.

___For ease of communication, I authorize this practice to contact me via unencrypted email. These communications may or may not include private information (such as name, date of birth, health condition, diagnosis, or billing/financial information). I understand the risks inherent in using unsecured/unencrypted communications.

I acknowledge that I may change my preference above at any time by notifying the practice in writing.

_____ _____ _____
Patient Name **Patient Signature** **Date**

All Media Release

I _____ hereby consent for Drs. Ford, Guter and Gray to use, reproduce, exhibit or distribute (in full or in part) any photographic, video, film and/or recording made of me or my likeness; and/or any written extract of such recording in which I may be included, for any purpose whatsoever, in any medium now known or invented in the future.

I hereby release discharge, and agree to hold harmless Drs. Ford & Guter D.D.S., Ltd. and all persons acting under its permission to authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

_____ _____ _____
Patient Name **Patient Signature** **Date**

Medicare
Private Contract

By signing this contract I understand and agree that that my oral and maxillofacial surgeon **will not** submit a claim to Medicare or its agents**, and I cannot submit** for services provided by **Ford & Guter D.D.S,Ltd** , even if such services would otherwise be covered.

- I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by **Ford & Guter D.D.S,Ltd**
- I understand that no claims will be submitted to Medicare and no Medicare reimbursement will be provided for these services.
- I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral and maxillofacial surgeon for services provided.
- I understand that Medigap plans do not, and other health and medical care insurance plays may elect not to, make payment for such services.
- I understand that I have the right to have services provided by other oral and maxillofacial surgeons or other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out.
- I understand that **Ford & Guter D.D.S,Ltd** are not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority, but rather they have opted-out of participating with Medicare.
- I understand that I will receive or have received a copy (a photocopy is permissible) of this contract, before services are rendered to me under the terms of this contract. **Ford & Guter D.D.S,Ltd** will retain the original contract and supply CMS a copy of this contract upon request.
- **Ford & Guter D.D.S,Ltd** understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

This contract is effective on _____ and it will expire on _____.
(date) (date)

Patient Name: _____ Date: _____

Patient or Legal Representative Signature: _____

Oral and Maxillofacial Surgeon's Signature: _____

Witness _____