Austin Oral & Maxillofacial Surgery Associates PA - Patient Information Sheet

Today's date : Account #:

PATIENT INFORMATION

Prefix: ______ Name First: ______ M: ______ Last: ______ Suffix: ______
Nickname: ______
Address: ______ City: ______ State: ______ Zip: ______
Home Ph#: ______ Work Ph: ______ Cell Ph: ______
Date of Birth: ______ Age: ______ Sex: Male/Female
SS#: ______ DL# ______
Dentist: ______ Physician: ______ Orthodontist (if applicable): ______
Referred by: ______
Employer: ______ Student: FT PT School Name: ______
E-Mail address: ______
Emergency Contact Name/Phone:

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

____ Self ____ Spouse ____ Mother ____ Father ____ Other ______
Name: ______ SS#: ______ DL#: ______
Address: ______ City: ______ State: ______ Zip: ______
Home Ph#: ______ Work Ph: ______ Cell Ph: ______
Date of Birth: Age: Sex: Male/Female Employer:

PLEASE NOTIFY THE FRONT STAFF IF YOU ARE BEING SEEN FOR A CONDITION RELATED TO AN ACCIDENT

INSURANCE INFORMATION

Your insurance is a method for you to receive reimbursement for fees you have paid to the doctor for services rendered
Having insurance is not a substitute for payment

PRIMARY DENTAL INSURANCE COMPANY	PRIMARY MEDICAL INSURANCE COMPANY
Dental Insurance Company:	Medical Insurance Company:
Insurance Address:	Insurance Address:
Insurance Ph#:	Insurance Ph#:
Policy Holder Name:	Policy Holder Name:
ID#:	ID#:
Policy Holder Address:	Policy Holder Address:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder SS#:	Policy Holder SS#:
Policy Holder Employer:	Policy Holder Employer:
Patient Relation to Policy Holder:	Patient Relation to Policy Holder:

SECONDARY DENTAL INSURANCE COMPANY	SECONDARY MEDICAL INSURANCE COMPANY
Dental Insurance Company:	Medical Insurance Company:
Insurance Address:	Insurance Address:
Insurance Ph#:	Insurance Ph#:
Policy Holder Name:	Policy Holder Name:
ID#:	ID#:
Policy Holder Address:	Policy Holder Address:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder SS#:	Policy Holder SS#:
Policy Holder Employer:	Policy Holder Employer:
Patient Relation to Policy Holder:	Patient Relation to Policy Holder:

HEALTH HISTORY

11/1/2009

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 changes 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, 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. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .... Y N
   - O. Radiation (X-ray) treatment for Cancer? .... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? .... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
   - S. Have you ever been tested for HIV/AIDS? .... Y N
     If so, what were the results? ___positive ___negative
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. Have you ever had a bone density test? .... Y N
   - J. Are you taking or **have you ever taken** Bisphosphonates For osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)? .... Y N
   - K. Have you ever been advised **not** to take a medication? .... Y N
   - L. Please list any and all medications taken, including prescription medications, 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 (Novocain, 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 narcotics? .... Y N
   - F. Latex or Rubber Products? .... Y N
   - G. Other allergies or reactions? Please, list .... Y N
     ____
     ____
9. Do you smoke or chew Tobacco? .... Y N
   How much per day?____________
10. Do you drink alcohol? .... Y N
    If so, frequency ________ & quantity________
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y N
12. Have you had any serious problems associated with any previous dental treatment? .... Y N
13. Have you or an immediate family member had any problem associated with anesthesia? .... Y N
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
15. Do you wish to talk to the doctor privately about anything? .... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** 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.

I understand the importance of an accurate Health History to assist the doctor in providing the best care possible. I have read and understand the questions and have answered completely and accurately.

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

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Medical Update: I have read my Health History dated ____________ and confirm that it adequately states past and present conditions.

Date ________ Exceptions or changes ________ Patient's Signature ________ Doctor's Initials ________

Date ________ Exceptions or changes ________ Patient's Signature ________ Doctor's Initials ________

A WORD ABOUT OUR FINANCIAL POLICY

PAYMENT FOR SERVICE

The payment for medical and dental services is the patient's responsibility. Our policy requires payment for services at the time the service is performed. If other arrangements are needed, please ask so that we may assist you. **We do not accept temporary checks. A $35.00 fee will be assessed on returned checks.**

INSURANCE:

- **CONTRACTED INSURANCE PLANS (HMO, PPO, DMO, etc.)**
  If our office has a contract with your insurance company, we will file all claims with them. You are responsible for payment of estimated co-insurance or co-pay due, at the time of service. It is the patient's responsibility to obtain required authorizations from the insurance company or primary care physician for each visit. Failure to have a current authorization could result in (1) rescheduling your appointment or (2) payment in full for all services relating to this appointment.

- **NON-CONTRACTED INSURANCE PLANS (Indemnity Insurance)**
  Filing your claim does not take the place of your responsibility to pay for services received. We ask that you pay your estimated co-pay, deductible, co-insurance, or non covered services at the time of your appointment.

It is important to recognize that your insurance policy is an agreement between you and your insurance company. Your benefit assignment does not take the place of your responsibility to pay for services received. Austin Oral & Maxillofacial Surgery is NOT responsible for determining or confirming insurance benefits. Verification of benefits is not a guarantee of payment by your insurance company; final determination is made by your insurance company at the time the claim is received. We do not coordinate benefits with secondary insurance carriers.

After we receive final payment or denial from your insurance company, you will be billed for the remaining balance on your account. If, after 60 days, your account remains unpaid, you will be responsible for the balance, and service charges of 18% APR will begin to accrue. In the event of an overpayment on your account, a refund will be sent to you within 60 business days.

In cases of divorced parents, the parent bringing the child to the initial visit will be deemed responsible for payment. Our office will not become involved in custody disputes over which parent is the responsible billing party.

I have read the above and understand that I am responsible for all office charges. I also understand that once payment has been received from my insurance company, any balance remaining on my account will be due within 30 days. I authorize the release of any medical or dental information necessary to process insurance claims and request payment of benefits to the provider of services.

____

Name of responsible party (please print)

____

Signature of responsible party **Date**

____

Patient name if different than the responsible party

Updated March 2, 2010

AUSTIN ORAL & MAXILLOFACIAL SURGERY 06/15/2010

Barry D. Cunningham, DDS, MSD
R. Lynn White, DDS
Gregory N. Burroughs, DDS
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Fred J. Voorhees, DDS, MSD
Brad A. Theriot, DDS
Andrea L. Quaroni, DDS, MD
Russell D. Cunningham, DDS, MD
Thomas S. Weil, DDS, MD
George M. Grant, DDS, PhD
James C. Fuselier, DDS, MD
Michael P. Ding, DDS, MD, *board eligible*

Diplomates, American Board of Oral and Maxillofacial Surgery • Fellows, American Association of Oral and Maxillofacial Surgeons

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Mopac – 512-346-7949
Marble Falls – 830-798-1054 | 888-322-8382
San Marcos – 512-396-4689
Lakeway – 512-263-9544
William Cannon – 512-447-6684
Georgetown – 512-869-0529
Temple – 254-771-1167
Medlink (after hours) – 512-323-5465

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.

____
{Please 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)

____

____

____

Austin Oral and Maxillofacial Surgery Associates, 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 (04/14/2003), 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 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 $25.00 for the first 20 pages, $.15 for each additional page, and $15 per x-ray 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: Janice Ashton

Telephone: 512/498-0110 Fax: 512/498-0120

E-mail: Janice@austinoms.com

Address: 711 W. 38th Street, Suite A-1; Austin, TX 78705