Rotary Way Oral Surgery

Oral and Maxillofacial Surgery • Reconstructive Surgery of the Jaws • Dental Implant Surgery
19 Rotary Way, Vallejo, CA 94591 • 707-642-0433 • Fax 707-642-5032 • Email: office@RotaryWayOralSurgery.com • RotaryWayOralSurgery.com

Patient Information Form

Today's Date: _____

Patient Name: First _____ MI _____ Last _____ Date of Birth _____

Address: _____
Street City State Zip

Phone: Home _____ Work _____ Mobile _____

SSN# _____ **Driver's License #** _____

Patient Employed By _____ Occupation _____ Phone _____

Address: _____
Street City State Zip

Sex ❒ Male ❒ Female **Marital Status** ❒ Married ❒ Single ❒ Divorced ❒ Separated ❒ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Home Phone _____ Mobile Phone _____

Is the patient a minor? ❒ Yes ❒ No **Full-time student?** ❒ Yes ❒ No **Name of School** _____

Name of Responsible Party: First _____ Last _____

Date of Birth: _____ **Relationship to patient:** ❒ Self ❒ Spouse ❒ Parent ❒ Other _____

If patient is a minor, primary residency: ❒ both parents ❒ Mom ❒ Dad ❒ step parent ❒ shared custody ❒ guardian

Address *if different from patient:* _____
Street City State Zip

Phone: Home _____ Work _____ Mobile _____

Employer *if different from above:* _____ Occupation _____ Phone _____

Address: _____
Street City State Zip

Dental Benefit Plan Information

Primary Dental Plan Name: _____ Phone _____

Address: _____
Street City State Zip

Name of Insured: _____ Date of Birth _____ ID Number _____

Policy Number: _____ Patient relationship to insured _____

Secondary Dental Plan Name: _____ Phone _____

Address: _____
Street City State Zip

Name of Insured: _____ Date of Birth _____ ID Number _____

Policy Number: _____ Patient Relationship to Insured _____

Medical Plan Information

Plan Name: _____ Phone _____

Address: _____
Street City State Zip

Name of Insured: _____ Date of Birth _____ ID Number _____

Policy Number: _____ Patient Relationship to Insured _____

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. **Please note: if you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit or Dental Service Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of appointments: We reserve the doctor's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are about to provide. To maintain the utmost service and care, we do require 48 hour notice to reschedule an appointment.

AUTHORIZATIONS: *(Please initial each item)*

_____ I understand the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services I may need and have consented to during diagnosis and treatment.

_____ I have read the above and agree to the financial and scheduling terms.

_____ I authorize the release of information necessary to process my dental benefit claim. I hereby authorize payment directly to this doctor otherwise payable to me. ❒ Yes ❒ No

_____ I give authorization to discuss my treatment and costs to:

_____

_____

_____

Signature: _____ **Date:** _____
Patient or legal guardian

Rotary Way Oral Surgery

CONFIDENTIAL MEDICAL HISTORY

Name:_____

1. Has there been any change in your general health in the last two years? Yes ☐ No ☐

2. Approximate date of last physical exam _____

3. Are you now under the care of a Physician? Yes ☐ No ☐

   For what?_____

4. Have you had any serious illness, operation or hospitalization within the past five years? Yes ☐ No ☐

   Please describe:_____

5. Are you taking medications of any kind (including over the counter medications)? Yes ☐ No ☐

   If yes, please list: _____

6. Are you allergic or have you reacted adversely to any medication or foods? Yes ☐ No ☐
   Have you had a bad reaction to:
   - Latex Yes ☐ No ☐
   - Local Anesthetics (Novocaine, Lidocaine) Yes ☐ No ☐
   - Penicillin or other Antibiotics Yes ☐ No ☐
   - Barbiturates, Sedatives or Sleeping Medicines Yes ☐ No ☐

7. Have you ever taken diet medication such as Fen-Phen Yes ☐ No ☐

8. Have you ever taken medication for osteoporosis/bone problems, such as:
   Boniva, Fosomax, Actonel, Zometa, Aredia or Bonefos? Yes ☐ No ☐

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Chronic sinus problems	Yes ☐ No ☐	Jaw joint pain or noises	Yes ☐ No ☐
Asthma, emphysema, bronchitis	Yes ☐ No ☐	Kidney disease or stones	Yes ☐ No ☐
Frequent hives or skin rash	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Current contagious diseases	Yes ☐ No ☐	Venereal disease	Yes ☐ No ☐
Rheumatic fever or heart murmur	Yes ☐ No ☐	Abnormal bleeding after surgery	Yes ☐ No ☐
Congenital heart disease	Yes ☐ No ☐	Hemophilia, anemia, sickle cell	Yes ☐ No ☐
Heart attack/open heart surgery	Yes ☐ No ☐	Radiation treatment for tumor	Yes ☐ No ☐
Chest pain/angina	Yes ☐ No ☐	Previous cancer	Yes ☐ No ☐
High blood pressure	Yes ☐ No ☐	Thyroid disease or goiter	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Systemic or immune deficiency disorders	Yes ☐ No ☐
Artificial joint surgery/implant	Yes ☐ No ☐	Problems with anesthesia	Yes ☐ No ☐
Shortness of breath after mild exercise	Yes ☐ No ☐	Problems with surgery	Yes ☐ No ☐
Seizures, epilepsy, fainting	Yes ☐ No ☐	History of face, lip or skin swelling	Yes ☐ No ☐
Diabetes or high blood sugar	Yes ☐ No ☐	Do you smoke or chew tobacco	Yes ☐ No ☐
Hepatitis, jaundice, liver disease	Yes ☐ No ☐	Malignant Hyperthermia	Yes ☐ No ☐
Arthritis or joint pain	Yes ☐ No ☐	Females:	
Do you wear contact lenses	Yes ☐ No ☐	Are you taking birth control pills?	Yes ☐ No ☐
Excessive use of alcohol/alcoholism	Yes ☐ No ☐	Are you pregnant? (____months)	Yes ☐ No ☐
Use of recreational/illicit drugs	Yes ☐ No ☐	Are you nursing?	Yes ☐ No ☐

Name of Physician_____City_____Phone_____

If there are other medical problems or conditions you think I should be aware of, please describe:

_____

_____

If you are completing this form for another person, what is your relationship to that person?_____

Your name: _____

I UNDERSTAND THAT THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED EACH QUESTION COMPLETELY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY WHO MAY RELEASE SUCH INFORMATION TO YOU.

_____ _____ _____ _____

Signature of Patient **Date** **Signature of Natural Parent/Legal Guardian** **Date**

(Minors only)

UPDATE: Has there been any change in medical history since this form was filled out? (Must be signed by patient, parent or legal guardian)

YES_____ NO _____ Signature_____Date_____

YES_____ NO_____ Signature_____Date_____

YES_____ NO _____ Signature_____Date_____

Patient Home Medication List

Please list all medications you are currently taking including all over the counter, vitamin or herbal supplements. Your accuracy in listing the medication name, dosage and frequency (how often or when you take it) are critical. This list will be used to guide the physician in prescribing the medications that you are given.

Medication Name	**Dosage**	**Frequency**	**Reason Taking Med**	**Comments** Please list any other pertinent information about how you take this medication
Over the Counter, Vitamin or Herbal	**Dosage**	**Frequency**	**Reason Taking Med**	**Comments**

Patient Name: _____

Patient Signature: _____

Primary Physician: _____

Please complete this form and bring it with you to your appointment. Thank you

ROTARY WAY ORAL SURGERY AND IMPLANTOLOGY

I hereby acknowledge receipt of Notice of Privacy Practices.

Name (print): _____

Signature: _____ Date: _____

If patient is a minor:

I am a parent or legal guardian of _____.
I hereby acknowledge receipt of Rotary Way Oral Surgery and Implantology, Notice of Privacy Practices with respect to the patient.

Circle one: Parent ***OR*** Legal Guardian-Print Name: _____

Signature: _____ Date: _____

This must be kept in the patient's file

NOTICE OF PRIVACY PRACTICES

Rotary Way Oral Surgery

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of **May 1, 2018** and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.