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

HEALTH HISTORY

Oral and Maxillofacial Surgeons treat primarily the mouth, jaws and related facial structures, but any health problems, medicines or drugs affect the treatment you receive. Because of our concern for you, we are obligated to ask the following questions. Please answer them as completely and as accurately as possible. Your answers will help guide our decisions on which treatment is best for you. Thank You.

PATIENT'S NAME:_____ AGE _____ WEIGHT_____SEX _____ HEIGHT _____
LAST FIRST MI

DOB____/____/_____

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

1. What is your "Chief Complaint" (What is your problem)?_____

Also, is your visit related to any of the following?

a. wisdom teeth [ ]
b. bad teeth [ ]
c. jaw or tooth pain [ ]
d. infection/swelling [ ]
e. loose teeth [ ]
f. bad breath [ ]
g. teeth sensitive to cold, heat, sweets or pressure [ ]
h. facial trauma (hit in face, broken jaw, etc.) [ ]
i. facial pain or headaches [ ]
j. growth in mouth [ ]
k. a bad bite [ ]
l. over-bite [ ]
m. jaw joint (TMJ) [ ]
n. implants [ ]

2. Is condition related to the patient's employment?..... [Y] [N]
3. Is condition related to an accident?..... [Y] [N]
   Give date: _____/_____/_____
4. Have you had previous consultation or treatment of the present problem?..... [Y] [N]
   With whom?_____
5. Address, phone of the person who sent you to us, if known:

_____

_____

_____

6. Present health (circle one)
   a. Physical..... Good Fair Poor
   b. Emotional..... Good Fair Poor
7. Has there been any change in your health in the past year?..... [Y] [N]
8. Have you been under care of a physician during the past two years?..... [Y] [N]
   a. What condition?_____
9. Date of your last physical exam by a physician:
   _____/_____/ 20____
10. Name and address of your physician:

_____

_____

_____

11. Have you ever been hospitalized?..... [Y] [N]

Reason for Hospitalization	*Hospital*	*Year*
_____	_____	_____
_____	_____	_____

12. Do you have, or have you had, any of the following diseases or problems?
    a. Glaucoma..... [Y] [N]
    b. Rheumatic fever or rheumatic heart disease..... [Y] [N]
    c. Heart murmur or mitral valve prolapse..... [Y] [N]
    d. Congenital heart disease..... [Y] [N]
    e. Heart surgery..... [Y] [N]
    f. Cardiovascular disease (heart trouble, heart attack attack, coronary insufficiency, coronary occlusion high blood pressure, low blood pressure atherosclerosis, stroke)..... [Y] [N]
    g. Do you get very short of breath after climbing one flight of stairs?..... [Y] [N]
    h. Do you get short of breath upon laying down?..... [Y] [N]
    i. Do your ankles swell during the day?..... [Y] [N]
    j. Do you ever feel that your heart is beating too fast or irregularly?..... [Y] [N]
    k. Have you ever had fainting spell?..... [Y] [N]
    l. Do you ever get pains in your chest over your heart?..... [Y] [N]
    m. Do you have a cardiac pacemaker?..... [Y] [N]
    n. Allergy..... [Y] [N]
    o. Sinus trouble or hay fever..... [Y] [N]
       have you been told you have nasal polyps?.. ..... [Y] [N]
    p. Respiratory problems, emphysema, bronchitis..... [Y] [N]
    q. Asthma..... [Y] [N]
       has asthma attack required emergency care?..... [Y] [N]
    r. Tuberculosis or other lung infection..... [Y] [N]
    s. A persistent cough or cough up blood..... [Y] [N]
    t. Hives or skin rash..... [Y] [N]
    u. Fainting, epilepsy, seizures..... [Y] [N]
    v. Nervousness or depression..... [Y] [N]
    w. Psychiatric problems..... [Y] [N]
    x. PTSD..... [Y] [N]
    y. Thyroid trouble..... [Y] [N]
    z. Addison's disease..... [Y] [N]
    aa. Diabetes (blood sugar)..... [Y] [N]
       How long?_____ Your last blood sugar?_____ mg/dl
       Your last Hb A1c_____% When was it done?_____
       1) Do you urinate more than six (6) times a day ..... [Y] [N]
       2) Are you thirsty much of the time?..... [Y] [N]
       3) Does your mouth frequently become dry?..... [Y] [N]
    bb. Hepatitis, jaundice or liver disease..... [Y] [N]
    cc. Gall bladder disease..... [Y] [N]
    dd. Stomach trouble..... [Y] [N]
    ee. Stomach ulcers..... [Y] [N]
    ff. Arthritis or rheumatism (painful swollen joints)..... [Y] [N]
    gg. Artificial joint replacement (hip or knee)..... [Y] [N]
    hh. Kidney trouble..... [Y] [N]
    ii. Anemia (low blood)..... [Y] [N]
    jj. Sickle cell anemia..... [Y] [N]
    kk. Hemophilia..... [Y] [N]
    ll. Venereal disease-STD (syphilis, gonorrhea)..... [Y] [N]
    mm. HIV or AIDS ..... [Y] [N]
    nn. Chills or fever..... [Y] [N]
    oo. Recent unwanted weight loss..... [Y] [N]
13. Do you have an immune system condition?..... [Y] [N]
    a. Frequent cold sores or herpes infections?..... [Y] [N]
    b. Thrush infection in the mouth?..... [Y] [N]
    c. Persistent swollen glands in the neck?..... [Y] [N]
    d. Persistent diarrhea or recent weight loss?..... [Y] [N]
14. Have you had a tumor or cancer? ..... [Y] [N]
    a. or radiation treatment in the head or neck area for tumor or cancer?..... [Y] [N]
15. Have you experienced prolonged bleeding following a tooth extraction, a cut, surgery or or injury?..... [Y] [N]
    a. Bruise easily?..... [Y] [N]
    b. Ever had blood transfusion?..... [Y] [N]
    c. Do you have frequent nose bleeds?..... [Y] [N]
16. Do you snore heavily after falling asleep?. ..... [Y] [N]
    a. Have you been told you stop breathing while asleep?.. [Y] [N]
    b. Do you fall asleep at inappropriate times, i.e. driving?.. [Y] [N]

17. Do you get motionsickness (car sick)..... [Y] [N]
18. Do you have headaches?..... [Y] [N]
    a. What area of your head aches?
       [ ] side [ ] front [ ] top [ ] back
    b. How often do you have them?
       [ ] daily [ ] weekly [ ] monthly [ ] seldom
    c. Are headaches? [ ] throbbing [ ] continuous ache
       [ ] sharp [ ] dull
19. Does your jaw click or pop when you chew?..... [Y] [N]
    a. Has your jaw ever click or popped when chewing?..... [Y] [N]
    b. Has your jaw ever hurt on opening wide?..... [Y] [N]
20. Does your jaw hurt when you chew?..... [Y] [N]
    a. Has your jaw ever hurt when chewing?..... [Y] [N]
    Where? [ ] In front of ear [ ] side of head [ ] side of jaw
21. Have you ever taken diet pills (Fen-Phen, Redux, etc)?..... [Y] [N]
22. Are you taking any medicine now?..... [Y] [N]
    Which of these:
    a. Antibiotics..... [Y] [N]
    b. Sulfa drugs..... [Y] [N]
    c. Anticoagulants (blood thinners)..... [Y] [N]
    d. High blood pressure medicine..... [Y] [N]
    e. Cortisone (steroids)..... [Y] [N]
    f. Tranquilizers..... [Y] [N]
    g. Antihistamines..... [Y] [N]
    h. Aspirin..... [Y] [N]
    i. Aspirin substitutes..... [Y] [N]
    j. Insulin (medicine for Diabetes)..... [Y] [N]
    k. Digitalis or drugs for heart trouble..... [Y] [N]
    l. Nitroglycerine (medicine for chest pain..... [Y] [N]
    m. Dilantin (medicine for seizures)..... [Y] [N]
    n. Antidepressants..... [Y] [N]
    o. Oral contraceptives (birth control pills)..... [Y] [N]
    p. Hormones..... [Y] [N]
    q. Bisphosphonates (Fosamax, Actonel) drugs to treat osteoporosis..... [Y] [N]
    r. Medical marijuana..... [Y] [N]
    s. Erectile dysfunction (Viagra, Cialis)..... [Y] [N]
    t. Please list <u>any and all</u> medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:

    _____
    _____
    _____
    _____

23. Is there any medicine you should be taking now?. [Y] [N]
24. Are you allergic to or have you reacted badly to?
    a. Local anesthetics (dental injections, spinal anesthesia)..... [Y] [N]
    b. Penicillin, Amoxicillin..... [Y] [N]
    c. Clindamycin like Cleocin®..... [Y] [N]
    d. Sulfa drugs like Bactrim®, Septra®..... [Y] [N]
    e. Erythromycin..... [Y] [N]
    f. Other antibiotics..... [Y] [N]
    g. Barbiturates..... [Y] [N]

(24. Cont'd) Are you allergic to or have you reacted badly to?
    h. Sedatives or sleeping pills..... [Y] [N]
    i. Aspirin..... [Y] [N]
    j. Aspirin substitutes like Tylenol®..... [Y] [N]
    k. Ibuprofen like Motrin® or Advil®..... [Y] [N]
    l. Iodine..... [Y] [N]
    m. Codeine like Tylenol #3®..... [Y] [N]
    n. Hydrocodone like Vicodin®, Norco®..... [Y] [N]
    o. Other narcotics..... [Y] [N]
    p. Latex..... [Y] [N]
    q. Eggs..... [Y] [N]
    r. Other foods..... [Y] [N]
    s. Other allergens:_____
25. Marital Status: ___Single ___Married __Separated ___Divorced __Widowed
26. Do you smoke or use tobacco in any form?..... [Y] [N]
    What?_____
    How much?_____ How long?_____
27. Have you used heroin, cocaine, marijuana, meth or other such drugs?..... [Y] [N]
28. Do you drink alcoholic beverages?..... [Y] [N]
    What?_____
    How much?_____ How long?_____
29. Date last dental check-up? _____/_____/20_____
30. Date last dental cleaning? _____/_____/20_____
31. Have you worn the same denture/partial more than 5 yrs.?..... [Y] [N]
32. Has patient or anyone in the family ever had problem with being put to sleep or being sedated for a medical or dental procedure?..... [Y] [N]
    Explain:_____
33. Father - Age___ Diseases_____ [Deceased]
    Mother - Age___ Diseases_____ [Deceased]
34. Is there a history of oral cancer in your family..... [Y] [N]
    a. Other cancers ..... [Y] [N]
35. Do you wear contact lenses?..... [Y] [N]
36. Are you wearing a removable dental appliance?..... [Y] [N]
37. Do you have a cold or sore throat?..... [Y] [N]
38. Have you had anything to eat or drink in the last 6 hours?..... [Y] [N]
39. Is there anything you would like to discuss in private with the doctor?..... [Y] [N]
40. **How do you feel about coming to us about your problem?**

☺	😐	☹
NO PROBLEM	**APPREHENSIVE**	**SCARED**

41. *Any other problem we should know about?*..... [Y] [N]
    What?_____

FOR WOMEN ONLY

42. Are you or do you think you may be pregnant?..... [Y] [N]
43. Are you nursing a baby?..... [Y] [N]
44. Do you have problems associated with your menstrual period?..... [Y] [N]
    Date of your last period _____/_____/_____

NOTES:

YOUR PRIMARY DENTIST'S NAME:_____ PHONE NUMBER: ( ) _____

YOUR PRIMARY PHYSICIAN'S NAME:_____ PHONE NUMBER: ( ) _____

I CERTIFY THAT ALL RESPONSES HEREIN GIVEN ARE TRUE AND CORRECT ABOUT MYSELF OR THE PATIENT BECAUSE, I UNDERSTAND THAT MY RESPONSES ASSIST IN DIAGNOSING AND PREPARING TO TREAT MY PROBLEM(S)

SIGNATURE OF PATIENT DATE

REVIEWED BY (for office use only) DATE

SIGNATURE OF OTHER (RELATIONSHIP) DATE

REVIEWED BY (for office use only) DATE

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 vour 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.