River Rock Oral Surgery

Ryan C. Swigert, DDS
Oral and Maxillofacial Surgeon

MEDICAL HISTORY

Patient: _____ Age: _____

Family Physician: _____ Physician's Telephone: _____

1. Have you been a patient in the hospital during the past two years? ..... ☐Yes ☐ No
2. Have you been under the care of a medical doctor during the past two years? ..... ☐Yes ☐ No
3. Are you taking prescription medications (including birth control medicine), herbal preparations or supplements?..... ☐Yes ☐ No
   PLEASE LIST: _____
4. Are you taking any medicine to prevent or treat osteoporosis?..... ☐ Yes ☐ No
5. Are you allergic or made sick by any medications?..... ☐Yes ☐ No
   PLEASE LIST: _____ **Latex:** ☐ Yes ☐ No **Egg/Soybean** ☐ Yes ☐ No
6. Circle any of the following conditions you have had or have at present:

Heart Surgery (any type)
_____ year
_____ year
STENTS (any type)
_____ year
Heart failure
Heart attack _____year
Heart valve problem
High blood pressure
Heart murmur
Congenital heart disease
Anemia
Bleeding Problems
Stroke
Artificial joint
_____area/year

Kidney trouble
Rheumatic fever
Ulcers/GERD
Emphysema/COPD
Asthma
Cough
Tuberculosis (TB)
Sinus trouble
Allergies or Hives
Diabetes
Thyroid disease
Radiation Treatment
_____reason/year
Chemotherapy
_____reason/year

Arthritis
Pain in jaw joints
HIV/AIDS
Hepatitis A (infectious)
Hepatitis B or C (serum)
Liver disease
Blood transfusion
_____reason/year
Cold sores
Fainting or dizzy spells
Epilepsy or seizures
Nervousness
Psychiatric treatment
Cancer
_____area/year diagnosed
Tumor
_____area/year diagnosed

7. List all previous surgeries and any complications _____
   Do you have any disease, condition or problem not listed?..... ☐Yes ☐ No
   PLEASE LIST: _____
8. Do you smoke or use tobacco products?..... ☐Yes ☐ No
   If so, AMOUNT (per day): _____
9. Do you or have you ever used any illegal drugs or someone else's prescription medicine? ☐Yes ☐ No
   If so **PLEASE LIST**: _____
10. WOMEN: Are you pregnant now? ..... ☐Yes ☐ No
    Are you breast-feeding? ..... ☐Yes ☐ No

To the best of my knowledge, all the preceding answers are true and correct. If there is any change in my health, or if medications change, I will inform the doctor at the next appointment.

_____

Signature of patient, parent, or guardian Date

REVIEWED _____/_____/_____/_____

PLEASE COMPLETE THE FOLLOWING

Confidential Information

Personal Information

Date:_____

Name_____

Mailing Address_____

City_____State_____Zip Code_____

Home Phone #_____

Birth Date_____

SSN _____

Married_____ Single_____ Divorced_____ Widowed_____

Spouse's or Guardian's Name_____

Person to contact for emergency_____

Phone #_____

Who may we thank for referring you? _____

Is another member of your family or relative a patient at our office? _____

Account Information

Person responsible for account:

_____

Occupation_____

Employer_____

Business Address_____

City_____

Business Phone_____

Your Spouse or Guardian

Name_____

Occupation_____

Employer_____

Business Address_____

_____

Business Phone_____

Payment is due at time of service. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for all fees incurred REGARDLESS OF MY INSURANCE. I hereby assign payment of dental benefits be made directly to River Rock Oral Surgery for services rendered in this office. There is a $25.00 fee for returned checks. If my account becomes delinquent and sent to a collection service I am responsible for all costs incurred.

Signature_____ **Date**_____

PRIMARY DENTAL INSURANCE

Insurance Carrier_____

Group #_____

Employer_____

Employee_____

Employee SSN_____Date of Birth_____

SECONDARY DENTAL INSURANCE

Insurance Carrier_____

Group #_____

Employer_____

Employee _____

Employee SSN_____Date of Birth_____

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Notice of Privacy Policy and Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW AND READ CAREFULLY.

Purpose of this Notice

Our office respects the privacy of personal information and understands the importance of keeping the information confidential and secure. This Notice describes out privacy practices with respect to your health information. Our privacy practices apply to current and former patients.

Types of Personal and Health We Collect

We collect a variety of personal and health information when delivering health care. You provide some of this information when you initially came into the office (such as address, social security number, and health history). We also receive additional personal and health information (such as eligibility) through our transaction with employers, insurance Companies and other health care providers. We limit the collection of personal information to that which is necessary to administer our business, provide quality service and meet regulatory requirements.

How We Protect Personal and Health Information

We treat personal and health information securely and confidentially. We limit access to personal information to only those personal who need to know information to provide service to patients (for example, our billing clerks and dental assistants). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet physical and health information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal and Health Information

We mat share any of the personal and health information we collect (as described above) with our associates as permitted by law. We may also disclose this information to non-associated entities or individuals as permitted or required by law. Non-associated with whom we may disclose information as permitted by law include our attorneys, accountants, a patient's authorized representative, other health care authorities, public health authorities, third party administrators, insurers and law enforcement or regulatory authorities. We may also disclose any of the personal and health information we collect (as described above) in order to provide appointment reminders or to give you information about other treatments of health-related benefits and services that may be of interest to you. In addition, in the event that this office is sold or merged with another office, you personal and health information will become the property of the new owner. We do not disclose personal or health information to any other third parties with out a patient's request or authorization.

Individual Rights to Access & Correct Personal and Health Information

We may have procedures for a patient to access personal, health or other information we collect. We will make this information available to the patient upon request. Our goal is to keep our patient information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal or health information we may have about you is not accurate, please let us know by contacting our Office Manager.

Further Information

This office reserves the right to amend this Notice of Privacy Practices at any time in the future.

River Rock Oral Surgery
Ryan C. Swigert, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices and am aware that my medical records may be transferred between offices or stored at an off-site secured facility.

_____
{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)