Auburn Oral Surgery and Implant Center

PATIENT INFORMATION

Title: (Mr., Mrs., Ms., Dr.) First Name_____ M.I. _____ Last Name_____

Sex: ☐ Male ☐ Female Date of Birth_____ Age_____ Social Security # _____

Street _____ City_____ State _____ Zip _____

Home Tel.# ( ) _____ Cell/Work Tel.# ( ) _____ Ext _____

Dentist _____ Physician _____ Referred By _____

Student: Full Time ☐ Part Time ☐ Not ☐ School Name/State_____

Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐

Employed: Full Time ☐ Part Time ☐ Retired ☐ Email Address: _____

IN CASE OF EMERGENCY

Name _____ Tel.# ( ) _____

Street _____ City_____ State _____ Zip _____

GUARANTOR (if patient is a minor)

Title: (Mr., Mrs., Ms., Dr.) First Name_____ M.I. _____ Last Name_____

Street _____ City_____ State _____ Zip _____

Home Tel.# ( ) _____ Work Tel.# ( ) _____ Ext _____

Social Security #_____ Relationship to patient _____ D.O.B._____

PATIENT'S DENTAL INSURANCE CO.

Insurance Co.:_____

Address _____

Tel.# ( ) _____

Group # _____ ID # _____

DENTAL INS. POLICY HOLDER NAME

Name of Policy Holder _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent

Sex: ☐ Male ☐ Female Date of Birth _____

Street _____

City _____ State _____ Zip _____

Tel.# ( ) _____ S.S. # _____

PATIENT'S DENTAL INSURANCE CO.

Insurance Co.:_____

Address _____

Tel.# ( ) _____

Group # _____ ID # _____

DENTAL INS. POLICY HOLDER NAME

Name of Policy Holder _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent

Sex: ☐ Male ☐ Female Date of Birth _____

Street _____

City _____ State _____ Zip _____

Tel.# ( ) _____ S.S. # _____

DENTAL INS. POLICY HOLDER'S EMPLOYMENT INFORMATION (Parent or Guardian if patient is minor)

Employer's Name Tel.# ( )

PATIENT'S MEDICAL INSURANCE CO.

Insurance Co.:_____

Address _____

Tel.# ( ) _____

Group # _____ ID # _____

MEDICAL INS. POLICY HOLDER NAME

Name of Policy Holder _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent

Sex: ☐ Male ☐ Female Date of Birth _____

Street _____

City _____ State _____ Zip _____

Tel.# ( ) _____ S.S. # _____

Health History

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit: _____

		Yes	No
1.	Are you in good health? _____ Height _____ Weight _____	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? _____ Date of last visit: _____ If so, for what are you being treated? _____	❑	❑
4.	Have you had any illness, operation or been hospitalized in the past five years? _____ _____	❑	❑
5.	Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so, describe where _____	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
6	Do you have a prosthetic joint?			
7	Rheumatic fever?			
8	Damaged heart valves / mitral valve prolapse?			
9	Heart murmur?			
10	High blood pressure?			
11	Low blood pressure?			
12	Chest pain, angina?			
13	Heart valve replaced?			
14	Heart attack(s)?			
15	Irregular heart beat?			
16	Cardiac pacemaker?			
17	Heart surgery?			
18	Bronchitis, chronic cough?			
19	Asthma?			
20	Hayfever / Sinus problems?			
21	Sleep Apnea?			
22	Emphysema?			
23	Difficult breathing / other lung trouble?			
24	Do you smoke? How much?			
25	Have you had a history of smoking?			
26	Do you smoke Marijuana ?			
27	Blood disorder such as anemia?			
28	Bruise easily / Blood Transfusion?			
29	Bleeding tendency (abnormal bleed)?			
30	Jaundice, hepatitis or liver disease?			
31	Fainting spells?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
32	Convulsions, epilepsy?			
33	Stroke?			
34	Thyroid trouble?			
35	Diabetes?			
36	Low blood sugar?			
37	Kidney trouble?			
38	Are you on dialysis?			
39	Swollen ankles, arthritis or joint disease?			
40	Stomach ulcers?			
41	Contagious diseases?			
42	Sexually transmitted diseases?			
43	Do you have any reason to be immunosuppressed?			
44	Delay in healing?			
45	A tumor or growth?			
46	Radiation treatment/chemotherapy?			
47	Chronic fatigue / night sweats?			
48	Are you on a diet?			
49	A history of drug abuse?			
50	A history of alcohol abuse?			
51	Eye disease / glaucoma?			
52	Mental health problems?			
53	A removable dental appliance?			
54	Pain & Clicking of jaws when eating?			
55	Malignant Hyperthermia?			
56	Any family history of anesthetic problems?			

MEDICATION							
ARE YOU NOW TAKING...	YES	NO	NOTES	ARE YOU NOW TAKING...	YES	NO	NOTES
1. Any kind of medicine, drugs, or pills?				4. Cortisone?			
2. Anticoagulants/Blood thinners?				5. Other medications (please list)			
3. Tranquilizers?				6. Bone density meds.?			

ALLERGIES							
ARE YOU ALLERGIC TO OR HAD A REACTION TO...	YES	NO	NOTES	ARE YOU ALLERGIC TO OR HAD A REACTION TO...	YES	NO	NOTES
6. Local Anesthetics?				10. Aspirin?			
7. Penicillin?				11. Codeine or other narcotics?			
8. Other antibiotics?				12. Other medications?			
9. Sodium pentothal, valium, or other tranquilizers?				13. Allergies other than drug allergies (Please List)			

History of taking Bisphosphonates: (Fosamax, Boniva, Zometa)? Yes ☐ No ☐

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? Yes ☐ No ☐ _____

WOMEN							
	YES	NO	NOTES		YES	NO	NOTES
14. Is there a possibility of pregnancy?				16. Are you nursing?			
15. Estimated delivery date? ____/____/____				17. Are you taking birth control pills?			

WOMEN NOTE: ANTIBIOTICS (SUCH AS PENICILLIN) MAY ALTER THE EFFECTIVENESS OF BIRTH CONTROL PILLS. CONSULT YOUR PHYSICIAN / GYNECOLOGIST FOR ASSISTANCE REGARDING ADDITIONAL METHODS OF BIRTH CONTROL.

Additional Information: _____

_____

_____

_____

_____

_____

_____

_____

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

SIGNATURE OF PATIENT _____ **DATE** _____
(Parent or Guardian if Minor)

Financial Obligation

I understand and acknowledge that <u>I AM PERSONALLY FINANCIALLY RESPONSIBLE FOR THE SERVICES PROVIDED FOR MYSELF, OR THE ABOVE NAMED, REGARDLESS OF INSURANCE COVERAGE. FULL PAYMENT/CO-PAYMENT IS DUE AT THE TIME OF SERVICE,</u> unless prior arrangements have been made with the office manager. <u>UPON MY FAILURE TO PAY ANY AMOUNT WHEN DUE. I AGREE TO PAY ALL COSTS OR EXPENSES INCURRED IN THE COLLECTION OF SUCH AMOUNT DUE, INCLUDING COURT COSTS.</u> This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

SIGNATURE OF PATIENT _____ **DATE** _____
(Parent or Guardian if Minor)

Auburn Oral Surgery
390 Southbridge St
Auburn MA 01501

ACKNOWLEDGEMENT OF RECIEPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this dental practice HIPPA notice of privacy practices

Authorization to release medical info if needed

This signature on file is my authorization for the release of any medical information / records required by Dr Laith Azzouni to obtain clearance for my surgical procedure done at AUBURN ORAL SURGERY.

Policy on Payment

Auburn Oral Surgery may, at its option, impose a $15 late fees on a monthly basis for up to three months should unpaid invoices remain open for more than thirty (30) days. The last fee gets added to your remaining balance. For example, if your balance due is $100.00 and it remains unpaid for over 90 days your new remaining balance will become $145. After 90 days, your account becomes eligible to be placed with a third-party collection agency.

CELL PHONE USE

☐ I provide consent for AOS dental practice to use my cell phone number to (choose one or both)

☐ Call

☐ Text

_____ Patient Name (Please print)

_____ Patient Signature DATE_____

AUBURN ORAL SURGERY & IMPLANT CENTER

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 April 14th 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 out 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 for any reason except those described in this Notice.

To Your Family and Friends: We may 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 your 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 you health information when we are required to do so by law.