PATIENT INFORMATION

THE ORAL SURGERY CENTER

Name _____ Date of Birth _____

Address _____ Sex ☐ Male ☐ Female ☐ Decline to Answer

City _____ State _____ Zip Code _____ What are your gender pronouns?

Phone Number (_____) _____ ☐ He/Him ☐ She/Her

Employer _____ ☐ Something Else [describe] _____ ☐ Decline to Answer

Work Number (_____) _____ Email address for confirmations:

Dentist _____ _____

Physician _____

Emergency Contact Name (not living with you) _____ Phone Number (_____) _____

Have you or a member of your family been seen in our office before? ☐ Yes ☐ No

Whom may we thank for referring you to this office? _____

PRIMARY DENTAL INSURANCE COMPANY HOLDER INFORMATION

Policy Holder Name _____ Relation to Patient _____

Policy Holder Address _____ Policy Holder DOB _____

City _____ State _____ Zip Code _____ Phone Number _____

Employer _____ Insurance Company _____

Policy/ID Number _____ Claims Address _____

Group Number _____ _____

SECONDARY DENTAL INSURANCE COMPANY HOLDER INFORMATION

Policy Holder Name _____ Relation to Patient _____

Policy Holder Address _____ Policy Holder DOB _____

City _____ State _____ Zip Code _____ Phone Number _____

Employer _____ Insurance Company _____

Policy/ID Number _____ Claims Address _____

Group Number _____ _____

AUTHORIZATION AND AGREEMENT

In signing this authorization and agreement, it is clearly understood that the fees of this office are set by this office and not bound by my insurance company's fee schedule. In the event that The Oral Surgery Center has a contractual agreement with my insurance company, they will abide by the obligations set forth in the contract. I hereby authorize The Oral Surgery Center to furnish to my insurance company all the information which may be requested. I acknowledge full responsibility for payment of this account and understand that any financial benefit allowed by my insurance company is solely a matter between the insurance company and me. I further acknowledge it is not the responsibility of The Oral Surgery Center to verify any such benefits, which may be allowed. I will make payment with the understanding I will be reimbursed in the event my insurance company makes payment.

Signature *(of person responsible for this account)* _____ Date _____

Printed Name _____ Phone Number (_____) _____

MEDICAL HISTORY FORM

THE ORAL SURGERY CENTER

NAME _____ **DATE OF BIRTH** _____

Weight _____ Height _____ Age _____

For the following questions check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit your responses will be reviewed and additional questions may be asked.

Yes No

☐ ☐ 1. Are you in good health?

☐ ☐ 2. Has there been any change in your general health within the past year? _____

☐ ☐ 3. My last physical examination was on _____

☐ ☐ 4. Are you now under the care of a physician?

Physician(s) Name _____

Physician(s) Address _____

☐ ☐ 5. Have you had any serious illness, operation, or been hospitalized in the past five years?

☐ ☐ 6. Have you ever had surgery? If yes, please describe:

_____

_____

☐ ☐ 7. Are you taking any medications(s) including non-prescription medication? If so, what medication(s) are you taking?

_____

_____

☐ ☐ 8. Do you routinely take prophylactic antibiotics prior to dental treatment?

☐ ☐ 9. Do you smoke cigarettes, e-cigarettes, vape or use chewing tobacco?

☐ ☐ 10. Have you previously smoked (used tobacco products?)? If yes, when did you quit? _____

☐ ☐ 11. Do you use alcohol? If yes, how often per week? _____

☐ ☐ 12. Do you use marijuana? if yes, how often per week? _____

☐ ☐ 13. Do you use recreational drugs? If yes, how often per week? _____

☐ ☐ 14. Have you had abnormal bleeding?

☐ ☐ a. If you answered yes to #14, have you ever required a blood transfusion?

☐ ☐ 15. Do you have any blood disorder such as anemia?

☐ ☐ 16. Have you ever had any treatment for cancer, a tumor or growth?

☐ ☐ a. If you answered yes to #16, have you ever taken a medication which alters bone metabolism such as bisphosphonates?

☐ ☐ b. Have you ever taken medication for osteoporosis?

17. Do you have, or have you had, any of the following problems:

Yes No

☐ ☐ Damaged heart valves or artificial valves, including heart murmur or rheumatic heart disease

☐ ☐ Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion)

☐ ☐ a. Do you have high blood pressure?

☐ ☐ b. Do you have chest pain upon exertion?

☐ ☐ c. Are you ever short of breath after mild exercise or when lying down?

☐ ☐ d. Do your ankles swell?

☐ ☐ e. Do you have inborn heart defects?

☐ ☐ f. Do you have a cardiac pacemaker?

☐ ☐ Do you have surgically placed artificial joints or other materials?

☐ ☐ Allergies or hay fever

☐ ☐ Sinus trouble

☐ ☐ Asthma

☐ ☐ Fainting spells or seizures

Yes No

☐ ☐ Persistent diarrhea or recent weight loss

☐ ☐ Diabetes ☐ Type 1 ☐ Type 2 Last A1C _____

☐ ☐ Hepatitis, jaundice or liver disease

☐ ☐ Condition which compromises the immune system

☐ ☐ Thyroid problems

☐ ☐ Respiratory problems, emphysema, bronchitis, COPD, etc.

☐ ☐ Arthritis or painful swollen joints

☐ ☐ Stomach ulcer or hyperacidity

☐ ☐ Kidney trouble

☐ ☐ Tuberculosis

☐ ☐ Persistent cough or cough that produces blood

☐ ☐ Persistent swollen glands in neck

☐ ☐ Low blood pressure

☐ ☐ Sexually transmitted disease

☐ ☐ Epilepsy or other neurological disease

☐ ☐ Cancer

☐ ☐ Sleep Apnea

18. Are you allergic or have you had a reaction to:

Yes	No		Yes	No	
☐	☐	Local anesthetics	☐	☐	Codeine or other narcotics
☐	☐	Penicillin or other antibiotics	☐	☐	Latex or rubber products
☐	☐	Sulfa drugs	☐	☐	Any other medications or products? *(Please list)*
☐	☐	Barbiturates, sedatives, or sleeping pills			
☐	☐	Aspirin			
☐	☐	Iodine			

Yes	No		
☐	☐	19.	Have you had any problems associated with local anesthesia, general anesthesia, and/or intravenous sedation?
☐	☐	20.	Have you had any serious trouble associated with any previous dental treatment?

If so, please explain:

_____

_____

_____

☐	☐	21.	Do you have any disease, condition, or problem not listed above that you think the doctor should know about?

If so, please explain:

_____

_____

_____

☐	☐	22.	Are you wearing contact lenses?
☐	☐	23.	Are you wearing removable dental appliances?
☐	☐	24.	Do you have pain in or near your ears or near your jaw joints?
☐	☐	25.	Does any part of your mouth hurt when clenched or feel tired upon awakening?
☐	☐	26.	Do you have chronic headaches, neck, or shoulder pain?
☐	☐	27.	Do you have a clicking jaw joint or other joint noise?
☐	☐	28.	Have you ever experienced any growth or sore spots in your mouth?
☐	☐	29.	Do you have any loose or sensitive teeth?
☐	☐	30.	Do your gums bleed?
☐	☐	31.	Is there anything you would like to discuss privately with the doctor?
☐	☐	32.	Are you pregnant?
☐	☐	33.	Are you nursing?
☐	☐	34.	Are you taking birth control pills?

PHARMACY PREFERENCE _____ **LOCATION** _____

PLEASE DESCRIBE WHY YOU ARE IN THE OFFICE TODAY _____

_____

_____

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

Signature of Patient *(Parent/legal guardian if under age 18)* _____ Date _____

Staff Initial _____ Date _____

MINNESOTA 651.233.2140 | **WISCONSIN** 715.690.3040
BILLING INQUIRIES 651.233.2141 | **ALL LOCATIONS FAX** 651.738.9048
TheOralSurgeryCenter.com

Patient HIPAA Acknowledgment and Consent to Share Information
The Oral Surgery Center
748 Bielenberg Drive
Woodbury, MN 55125

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I consent to the disclosure of my health records to any providers involved in my care or treatment, to health plans, to others as needed for payment purposes, to others as needed to improve the quality of my care and experience and/or to manage The Oral Surgery Center's business operations. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by The Oral Surgery Center of the practice's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been offered a copy of the *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that The Oral Surgery Center restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that The Oral Surgery Center is not required to accept requested restrictions but if agreement is approved, The Oral Surgery Center is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that The Oral Surgery Center has taken action relying on this consent.

HIPAA Privacy issues can arise when using cell/smart phones in areas of The Oral Surgery Center where patients and/or patient information may end up in photos or audio recordings. Patients and/or discussions may be in the background, and this information may be picked up in the photo or audio recording.

To ensure confidentiality and privacy, the use of camera phones and personal digital assistants (PDAs) for the purpose of video-taping patients for non-clinical purposes is strictly prohibited.

Electronic Communication Acknowledgement

I _____ DO AGREE (Initial)
I_____ DO NOT AGREE (Initial)
That The Oral Surgery Center may communicate with me electronically at the email address and/or mobile phone number listed below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing The Oral Surgery Center any updates to my email address and/or mobile phone number. The Oral Surgery communicates appointment reminders via text, email, and phone call.

Preferred contact information:
Mobile phone: _____
Email: _____

I can withdraw my consent to electronic communications at any time by calling:
The Oral Surgery Center|651.233.2140 or 715.690.3040|or by emailing referrals@theoralsurgerycenter.com.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Right of Access for Family Member/Friend
In addition to the disclosures outlined above, I direct The Oral Surgery Center to disclose and release my protected health information described below to:

Family Member/Friend Name: _____ Relation: _____

Information to be Disclosed: _____ (if left blank, all information will be discussed)

Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective October 1, 2017

This Notice of Privacy Practices identifies the general ways your protected health information can be used or disclosed. Protected health information is the individually identifiable personal health information found in your medical and billing records. This information is created or received by a health care provider, insurance company, or employer, and relates to your past, present, or future physical or mental health conditions or the payment for health care services. This information can be transmitted or maintained in any form by The Oral Surgery Center.

This Notice describes your legal rights regarding your protected health information. It also informs you of the legal duties and privacy practices of The Oral Surgery Center.

For the purpose of this Notice, the terms "you" or "your" refers to the patient who is the subject of the protected health information. The terms "we", "our" or "us" refers to The Oral Surgery Center.

OUR LEGAL DUTIES

We are required, by law, to keep your identifiable protected health information private; provide you with this Notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of the Notice as long as it is in effect. If we revise this Notice, we will follow the terms of the revised Notice, as long as it is in effect.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following information describes how we are permitted, or required by law, to use and disclose your protected health information. Not every use or disclosure in a category will be listed.

Treatment: We may use or disclose your protected health information to a physician, dentist, or other health care provider, in or outside of The Oral Surgery Center, in order to provide care and treatment to you. An example of this includes communicating with your general dentist regarding extracting a tooth. We may contact you to provide appointment reminders and to provide you with information about health-related services provided by The Oral Surgery Center, or treatment alternatives that may be of interest to you.

Payment: We may use or disclose your protected health information to obtain payment for services we provide to you. We may disclose your protected health information to another health care provider or entity. For example, we may need to provide your health plan with information about surgery you received so your health plan will pay The Oral Surgery Center or reimburse you for the surgery. The Oral Surgery Center also will tell your health plan about a treatment you are going to receive to obtain the health plan's prior approval for this treatment or to determine whether your plan will cover the treatment.

Health Care Operations: We may use or disclose protected health information about you to support the programs and activities of The Oral Surgery Center such as quality and service improvement; health care delivery review; regulatory compliance, staff performance evaluation; competence or qualification review of health care professionals; education and training of physicians and other health care providers; and

business planning and development, business management and general administrative activities. We use this information to continuously improve the quality of care for all patients we serve. For example, we may combine protected health information about many patients to evaluate the need for new services or treatments. We may disclose information to doctors, nurses, and other students for educational purposes.

Additionally, we may share your protected health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your protected health information.

Authorization for Other Disclosures: We will not use or disclose your protected health information, except as described throughout this document, unless you authorize us, in writing, to do so. You can revoke an authorization at any time, in writing. If you revoke an authorization, we will no longer use or disclose your protected health information for the purpose covered by the authorization. However, we are unable to take back any uses or disclosures already made with your authorization. Specific examples of uses or disclosures requiring authorization include: use of psychotherapy notes, marketing activities, the sale of your protected health information and most non-treatment uses and disclosures for which we are compensated.

Family and Friends: We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, of your location and general condition. We will also disclose protected health information to a family member, other relative, close personal friend, or any other person you identify, if the information is relevant to that person's involvement with your care or payment for your care. You can prohibit disclosure of this information.

Future Communications: We may use or disclose your information to communicate with you via newsletters, mailings or other means regarding treatment options, health related information, disease-management programs, or other community based initiatives or activities in which The Oral Surgery Center participates. If we receive any financial compensation for such communications (with limited exceptions), we will obtain your authorization prior to sending the communication and your authorization can be revoked at any time.

Public Health and Safety: We may use or disclose your protected health information, as authorized or required by local, state or federal law, for the following purposes deemed to be in the public interest or benefit:

- To report certain diseases and wounds, births and deaths, and suspected cases of abuse, neglect, or domestic violence;
- To help identify, locate, or report criminal suspects, crime victims, suspicious deaths, or criminal conduct on the premises of The Oral Surgery Center;
- To respond to a court order, subpoena, or other judicial process;
- To assist federal disaster relief efforts;
- To enable product recalls, repairs, or replacements;
- To respond to an audit, inspection, or investigation by a health-related government agency;
- To assist in federal intelligence, counterintelligence, and national security issues;
- To facilitate organ and tissue donations;
- To assist coroners, medical examiners, and funeral directors;
- To respond to a request from a jail or prison regarding an inmate's health or medical treatment;
- To respond to a request from your military command authority (if you are a member or veteran of the armed forces); To provide information to a workers' compensation program.

Business Associates: There are some services provided at The Oral Surgery Center through contracts with business associates. When these services are contracted, we may disclose your protected health information to the business associate so they can perform the job we have asked them to do. However, business associates are required by federal law to appropriately safeguard your information.

Confidential Communications: You have the right to request that we communicate protected health information to you by an alternate means or location other than your home address and telephone number. Your request must be made in writing to The Oral Surgery Center's Privacy Officer, and must specify how or where you wish to be contacted. We will try to accommodate your request for alternate communications. If you request an alternate means of communication, that request should also be communicated by you to each of your physicians.

Restrictions: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. To request a restriction, you must make your request in writing to the Privacy Officer. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Additionally, you have the right to request that we not use or disclose your protected health information to a health plan for purposes of payment or health care operations (not for treatment) if the information pertains solely to a health care item or service that has been paid for out-of-pocket and in full. Your request for restriction must be submitted in writing to The Oral Surgery Center. In this case, The Oral Surgery Center must honor your request. However, you should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

Access: You have the right to review and obtain a copy of your health information, with certain exceptions. Usually, this includes medical and billing records, but does not include psychotherapy notes. Your request to review or obtain a copy of your health information must be in writing to our Privacy Officer. You will be charged fees as authorized by law. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Amendment: If you feel that the health information we have about you is incorrect or incomplete, you have the right to ask for an amendment of that information. You have the right to request an amendment for as long as the information is kept by or for us. Your request for an amendment must be made in writing to our listed Privacy Officer, and include a reason that supports your request. We do not have to honor your request but will advise you of our decision in writing.

Accounting of Disclosures: You have the right to receive a list of certain disclosures of your protected health information that we have made within the last six years. Your request for an accounting must be in writing to our listed Privacy Officer, and must state a time period for which you want an accounting. You may request one accounting free of charge within a 12-month period. A fee will be charged for additional lists within this same time period.

Breach Notification: In certain instances, you have the right to be notified in the event that we, or one of our Business Associates, discover an inappropriate use or disclosure of your protected health information. Notice of any such use or disclosure will be made in accordance with state and federal requirements.

Revisions of this Notice: We reserve the right to change this Notice, and the right to make the new provisions effective for all health information we currently maintain, as well as any information we receive in the future. If we make a major change to this Notice, the revised Notice will be posted in **The Oral Surgery Center**'s place of business and on **The Oral Surgery Center**'s web site. In addition, a paper copy of the revised Notice will be available upon request.

To Report a Complaint: If you believe your protected health information privacy rights have been violated, you can file a complaint with us by mail, at the address provided in this Notice. You may also file a complaint with the Secretary of the United States Department of Health and Human Services, Office of Civil Rights, by completing a Health Information Privacy Complaint Form (available at) https://www.hhs.gov/hipaa/filing-a-complaint/index.html) and sending it to the applicable OCR Regional Office listed on the form, or by calling 1-800-368-1019 for instructions and contact information. There will not be any penalty or retaliation against you for making a complaint to us or to the Department of Health and Human Services.

Copy of Notice: You have the right to a paper copy of this Notice. In addition, a copy of this Notice also may be obtained at our web site, www.theoralsurgerycenter.com.

Contact Person: If you have any questions or need information regarding our legal duties and privacy practices, or how to exercise any of your protected health information rights listed in this Notice, please contact:

Privacy Officer
The Oral Surgery Center
748 Bielenberg Drive
Woodbury, MN 55125
651-233-2140