Patient Information

Date_____

Last Name_____ First Name_____ MI_____

Address_____ Apt #_____ City_____

State_____ Zip_____ D.O.B._____ Age_____ SS#_____

Home #_____ Cellphone #_____ Work#_____

Employer_____ Position_____

Business Address_____ City_____ State_____ Zip_____

In Case of Emergency-Contact: _____ Relationship_____ Phone_____

Person Responsible for Account/Name of Insured_____

Insured Member D.O.B._____ TX Drivers Lic.#_____

Name of Dental Insurance Company_____ Phone #_____

Insurance Address_____

Member ID/Social Security #_____ Group#_____

Personal Physician_____Phone#_____

Pharmacy Name_____Phone#_____

Pharmacy Address_____

General Dentist_____

Address_____ Phone#_____

Whom May We Thank for This Referral? Name_____

Address_____ Phone#_____

*I Authorize Release of Any Information Relating to This Claim.

_____ _____

Signature (Patient or Parent/Legal Guardian) Date

MEDICAL HISTORY FORM

Date_____

Name_____ Sex_____ Height_____ Weight_____ Age_____

Purpose of Visit_____

Drug Allergies? ( ) Yes ( ) No * If yes, list name of drug and reaction that occurred

_____

Medications Taking: List dosage, amount, and quantity taking per day

_____

_____

_____

Indicate which of the following you have, or have had in the past (Please check Y or N)

ADD/ADHD	( ) Yes ( ) No	Heart Attack	( ) Yes ( ) No
AIDS/HIV Positive	( ) Yes ( ) No	Heart Murmur	( ) Yes ( ) No
Alzheimer's Disease	( ) Yes ( ) No	Heart Problems	( ) Yes ( ) No
Anaphylaxis	( ) Yes ( ) No	Heart Surgery	( ) Yes ( ) No
Anemia	( ) Yes ( ) No	Hepatitis	( ) Yes ( ) No
Angina/Chest Pain	( ) Yes ( ) No	Herpes	( ) Yes ( ) No
Arthritis	( ) Yes ( ) No	High Blood Pressure	( ) Yes ( ) No
Artificial Heart Valve	( ) Yes ( ) No	High Cholesterol	( ) Yes ( ) No
Artificial Joints	( ) Yes ( ) No	Irregular Heart Beat	( ) Yes ( ) No
Asthma	( ) Yes ( ) No	Kidney Problems	( ) Yes ( ) No
Bleeding Disorder	( ) Yes ( ) No	Liver Problems	( ) Yes ( ) No
Blood Transfusion	( ) Yes ( ) No	Mental Health Problems	( ) Yes ( ) No
Breathing Problems	( ) Yes ( ) No	Nervous Disorders	( ) Yes ( ) No
Bronchitis	( ) Yes ( ) No	Organ Transplant	( ) Yes ( ) No
Bruise Easily	( ) Yes ( ) No	Osteoporosis	( ) Yes ( ) No
Cancer/Tumor	( ) Yes ( ) No	Pace Maker	( ) Yes ( ) No
Chemo/Radiation	( ) Yes ( ) No	Sinus Problems/Allergies	( ) Yes ( ) No
Diabetes	( ) Yes ( ) No	Steroid Treatment	( ) Yes ( ) No
Dialysis	( ) Yes ( ) No	Stomach Problems	( ) Yes ( ) No
Dizziness/Fainting	( ) Yes ( ) No	Stroke	( ) Yes ( ) No
Drink Alcohol	( ) Yes ( ) No	Taken Bisphosphonate	( ) Yes ( ) No
Drug Abuse	( ) Yes ( ) No	Thyroid Disorder	( ) Yes ( ) No
Epilepsy/Seizures	( ) Yes ( ) No	Tuberculosis	( ) Yes ( ) No
Eye Disease	( ) Yes ( ) No	Use Tobacco Products	( ) Yes ( ) No

*Female Patients: Are you…

Pregnant/Trying to conceive ( ) Yes ( ) No Taking Oral Contraceptives ( ) Yes ( ) No Nursing ( ) Yes ( ) No

Surgeries/Hospitalizations: ( ) Yes ( ) No * If yes, please list reasons and dates_____

_____

Any Complications with Medical/Dental Treatments: ( ) Yes ( ) No *If yes, please explain

_____

Are you under a Doctor's care now? (Other than Primary Care Physician) ( ) Yes ( ) No

*If yes, please list name and phone number_____

Do you have any other information that you think I should know about? ( ) Yes ( ) No

*If yes, please explain_____

HISTORY OF PRESENT DENTAL ILLNESS

Does your mouth hurt now? ( ) Yes ( ) No Sensitivity to Hot/Cold? ( ) Yes ( ) No Fever Blisters? ( ) Yes ( ) No

Do you grind your teeth? ( ) Yes ( ) No Jaw Joints Hurt/Pop? ( ) Yes ( ) No Orthodontics (Braces) ( ) Yes ( ) No

I Understand and have answered all of the above questions to the best of my ability and I consent to x-rays and photos to be used for diagnostic and teaching purposes.

_____ _____

Patient or Guardian Signature Date

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;

- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Elect to opt out of receiving further fundraising communications from the office/hospital
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Medical Center Oral Surgery, P.A., in person or in writing, during normal hours. They will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you, and
- Notify you if you are affected by a breach of unsecured PHI

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Medical Center Oral Surgery, P.A. at 713-790-9474.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr. B.L. Remedios.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification
Unless you object, 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, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

Revised Forms Effective Date: August 1, 2013

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Name Date

Medical Center Oral Surgery

Dr. B. L. Remedios

INSURANCE BENEFITS AND COVERAGE

THE BENEFITS AND PATIENT PORTION DUE THAT WE QUOTE TO YOU ARE GIVEN TO US OVER THE PHONE FROM YOUR INSURANCE CARRIER IS AN ESTIMATE ONLY! INSURANCE COMPANIES DO NOT GUARANTEE BENEFITS UNTIL THEY ACTUALLY PROCESS THE CLAIM. AN ESTIMATE IS NOT A GUARANTEE OF FULL PAYMENT FOR SERVICES RENDERED.

****IF YOU WANT TO KNOW THE EXACT AMOUNT THAT YOU NEED TO PAY FOR YOUR SURGICAL PROCEDURE THEN ASK US TO FILE A PRE-DETERMINATION WITH YOUR INSURANCE COMPANY SO THEY MAY PROCESS IT. THIS WILL TAKE ANYWHERE FROM 4 TO 6 WEEKS FOR THEM TO SEND A PRE-DETERMINATION ESTIMATE BACK TO US. YOU MAY THEN SCHEDULE YOUR SURGERY AFTER WE RECEIVE THAT BACK FROM THEM.****

YOU WILL BE RESPONSIBLE FOR THE AMOUNT THAT YOUR INSURANCE CARRIER ESTIMATES ON THE DAY OF SURGERY AND ANY AMOUNT NOT PAID OR COVERED BY YOUR INSURANCE COMPANY AFTER THE CLAIM HAS BEEN PROCESSED.

THIS BALANCE IS DUE WITHIN 30 DAYS AFTER INSURANCE PAYMENT HAS BEEN RECEIVED.
ANY AMOUNT NOT PAID AFTER 30 DAYS WILL BE SENT TO COLLECTIONS.

_____ _____

NAME OF RESPONSIBLE PARTY (PRINT) **DATE**

_____

SIGNATURE OF RESPONSIBLE PARTY

MEDICAL CENTER ORAL SURGERY

Dr. B.L.REMEDIOS

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPPA privacy gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by the alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

- **Home Telephone** _____ **Cell Number**_____
- Leave detailed message
- Leave message with call-back number only
- **Written Communication**
- Mail to my home address
- Mail to my work/office address

Fax to number indicated_____

I allow you to give my clinical information to or answer questions from(check all that apply)

- Spouse_____
- Parent_____
- Child_____
- Other (specify_____
- NONE_____

_____ _____

Patient/ Guardian Signature Date

_____ _____

Print Name Birth date

BROKEN APPOINTMENT POLICY
MEDICAL CENTER ORAL SURGERY
DR. B.L. REMEDIOS

PLEASE BE ADVISED THAT WE HAVE AN OFFICE POLICY CONCERNING BROKEN APPOINTMENTS IN OUR OFFICE. THIS INCLUDES: NO SHOWS AND LAST MINUTE CANCELLATIONS FOR **SCHEDULED SURGERIES ONLY.** THERE WILL BE A $100.00 FEE CHARGED FOR NOT SHOWING FOR SURGICAL APPOINTMENTS AND/OR CANCELLING LESS THAN 48 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT. THIS TIME IS REQUESTED TO ALLOW US TO SCHEDULE ANOTHER PATIENT IN THAT TIME SLOT.

*NOTE: WE DO HAVE AN AFTER HOURS ANSWERING SERVICE TO LEAVE MESSAGES-INCLUDING WEEKENDS.

EMERGENCY SITUATIONS FOR CANCELLATIONS WILL BE CONSIDERED AT THE OFFICE MANAGER'S DISCRETION FOR FEE TO BE WAIVED.

THIS POLICY IS ENFORCED TO RESPECT THE TIME OF DR. REMEDIOS, STAFF, AS WELL AS OTHER PATIENTS. THANK YOU FOR UNDERSTANDING.

_____

Patient/Guardian Signature Date