Oral and Maxillofacial Surgeons

OF NORTHERN ARIZONA • *Dr. Todd Dingman, DDS, MD*

HEALTH HISTORY

Patient's Name____

Age/Date of Birth____

Today's Date____

Please answer all questions by circling Yes (Y) or No (N)
All responses are kept confidential.

- Are you in good health?........ Y N
- Has there been any change in your general health in the last year........ Y N
- Date of last physician's exam________________________
- Are you now under a physician's care for a particular problem?........ Y N
- Have you ever had any serious illnesses, operations or hospitalization? Y N
- If so, please describe on back of sheet.
- Height _______ Weight _______

Do you have or have you ever had:

- Rheumatic fever or rheumatic heart disease?........ Y N
- Congenital heart disease?........ Y N
- Cardiovascular disease (heart attack, heart trouble, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)?........ Y N
- Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath,chest pain, severe coughing)?........ Y N
- Seizures, convulsions, epilepsy, fainting or dizziness?........ Y N
- Bleeding disorder, anemia, bleeding tendency, blood transfusion?........ Y N
- Do you bleed easily?........ Y N
- Liver disease (jaundice, hepatitis)?........ Y N
- Kidney disease?........ Y N
- Diabetes?........ Y N
- Thyroid disease (golter)?........ Y N
- Arthritis?........ Y N
- Stomach ulcers or colitis?........ Y N
- Glaucoma?........ Y N
- Osteoporosis?........ Y N
- Implants placed anywhere in your body (heart valve, pacemaker, hip, knee)?........ Y N
- Radiation (x-ray) treatment for cancer?........ Y N
- Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?........ Y N
- Sinus or nasal problems?........ Y N
- Any disease, drug or transplant operation that has depressed your immune system?........ Y N

Are you using any of the following:

- Antibiotics?........ Y N
- Anticoagulants (blood thinners)?........ Y N
- Aspririn or drugs such as Motrin, Alieve, Ibuprofen?........ Y N
- High blood pressure medications?........ Y N
- Steroids (cortisone, etc.)?........ Y N
- Tranquilizers?........ Y N
- Insulin or oral anti-diabetic drugs?........ Y N
- Digitalis, Inderal, nitroglycerin, or other heart drug?........ Y N
- Are you taking or have you ever taken bisphosphonates for osteoporosis, multiple myeloma, or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)?........ Y N
- Please list any and all medications taken, including perscription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: ____________________
____
____

Are you allergic to or have you had an adverse reaction to:

- Local anesthesia (Novocain, etc.)?........ Y N
- Penicillin or other antibiotics?........ Y N
- Sedatives, barbiturates?........ Y N
- Aspirin or Ibuprofen?........ Y N
- Codeine or other pain killers?........ Y N
- Latex or rubber products?........ Y N
- Other allergies or reactions?........ Y N

- Do you smoke or chew tobacco?........ Y N
- How much per day? ____________________
- Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?........ Y N
- Have you had any serious problems associated with any previous dental treatment?........ Y N
- Have you or any immediate family member had any problem associated with intravenous anesthesia?........ Y N
- Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?........ Y N
- Do you wish to talk to the doctor privately about anything?........ Y N

For women only

- Are you pregnant or is there any chance that you might be pregnant? Y N
- Are you nursing? .... Y N
- **If you are using oral contraceptives,** it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date________________________________

____

Signature of person completing Health History

Doctor's Initials ________

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PATIENT INFORMATION

Today's date_______________________

❐ Mr. ❐ Mrs. ❐ Ms. ❐ Dr. First name _______________ M.I. _______ Last name _______________

❐ Male ❐ Female Birth date __________ Age _______ S.S.# _______________ Email _______________

Street_______________ Apt. _______ City _______________ State _______ Zip _______

Home Telephone (____) __________ Cell (____) __________ Have you been a patient of our practice? ❐ Yes ❐ No

Referred by (first/last name) _______________ Has a family member ever been a patient of our practice? ❐ Yes ❐ No

Dentist (first/last name) _______________ Medical doctor (first/last name) _______________

Driver's license # __________ Nearest relative not living with you (first/last name) _______________ Tel (____)__________

Employer _______________ Bus. Tel. (____) __________ Personal payment type: ❐ Cash ❐ Check ❐ Credit card

In case of an emergency contact (first/last name)_______________ Tel. (____) __________ Relation __________

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT

❐ Self (If self, skip this section) ❐ Spouse ❐ Father ❐ Mother ❐ Other _______________

Name_______________ S.S.#_______________ Birthdate__________ Age _______

Telephone (____) __________ Cell (____) __________ Email _______________

Street_______________ Apt. _______ City _______________ State _______ Zip _______

Driver's license #_______________ Employer _______________ Bus. Tel. (____) __________

SPOUSE OR OTHER GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE)

Name _______________ Relation __________ S.S.# _______________ Birth date __________

Street_______________ Apt. _______ City _______________ State _______ Zip _______

Telephone (____) __________ Employer _______________ Bus. Tel. (____) __________

INSURANCE INFORMATION

Student ❐ Full time ❐ Part time ❐ Not School name and address_______________

Marital status ❐ Married ❐ Divorced ❐ Widowed ❐ Single ❐ Legally separated City/State/Zip _______________

Employed ❐ Full time ❐ Part time ❐ Retired ❐ Not Do you belong to a PPO or an HMO? ❐ Yes ❐ No

PRIMARY DENTAL INSURANCE COMPANY

Employer_______________

Bus. address/city/state/zip _______________

Bus. tel. (____) __________ Plan __________

Insurance Co. Name _______________ ID# __________

Address/city/state/zip _______________

Tel. (____) __________ Group name __________

Group # __________ Insured party __________

Relation__________ Birth date __________ Sex: ❐ M ❐ F

S.S.#_______________ Tel. (____) __________

Address/city/state/zip _______________

PRIMARY MEDICAL INSURANCE COMPANY

Employer_______________

Bus. address/city/state/zip _______________

Bus. tel. (____) __________ Plan __________

Insurance Co. Name _______________ ID# __________

Address/city/state/zip _______________

Tel. (____) __________ Group name __________

Group # __________ Insured party __________

Relation__________ Birth date __________ Sex: ❐ M ❐ F

S.S.#_______________ Tel. (____) __________

Address/city/state/zip _______________

SECONDARY DENTAL INSURANCE COMPANY

Employer_______________

Bus. address/city/state/zip _______________

Bus. tel. (____) __________ Plan __________

Insurance Co. Name _______________ ID# __________

Address/city/state/zip _______________

Tel. (____) __________ Group name __________

Group # __________ Insured party __________

Relation__________ Birth date __________ Sex: ❐ M ❐ F

S.S.#_______________ Tel. (____) __________

Address/city/state/zip _______________

SECONDARY MEDICAL INSURANCE COMPANY

Employer_______________

Bus. address/city/state/zip _______________

Bus. tel. (____) __________ Plan __________

Insurance Co. Name _______________ ID# __________

Address/city/state/zip _______________

Tel. (____) __________ Group name __________

Group # __________ Insured party __________

Relation__________ Birth date __________ Sex: ❐ M ❐ F

S.S.#_______________ Tel. (____) __________

Address/city/state/zip _______________

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NOTICE OF POLICY 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 carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your heath information for purposes of treatment, payment, and health care operations. Protected health information we created and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, 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.

- **Your Health Information Rights:**
  The heath 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
- Obtain a paper copy of this Notice of Privacy for Protected Health information ("Notice") by making a request at our office.
- 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 excerpt in certain circumstances.
- Requests that your health care record be attended 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 a future disclosures or 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,
- Revoke authorizations that you made previously to us or disclose information except to the extent information or activities has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Todd A. Dingman in writing during normal hours. He will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this notice before signing the consent authorization use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

This 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, and
- Accommodate you reasonable requests regarding methods to communicate health information with you.

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 retain. 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 any questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office in order to do so. Additionally, if you believe your privacy rights have been violated, you may file a complaint at our office by delivering a written complaint to Todd A. Dingman. You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services.

- 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 or 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, a 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 recalls, repairs, or replacements.

- **Workers Compensation.** If you are seeking compensation through Workers Compensation, we may disclose you protected health information to the extent necessary to comply with the 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 and 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 it's agents, you protected health information necessary for your health and the health and safety of other individuals.

- **Law Enforcement**. We may disclose your protected heath 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 heath information to appropriate health oversight agencies or for health oversight activities.

- **Judicial/Administrative Proceedings**. We may disclose your protected heath information in the course of any judicial or administrative proceedings 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 the Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorizations as previously provided.

- **Website**. If we maintain a website that provides information about our entity, this notice will be on our website.

Patient Signature ____

THE FOLLOWING POLICIES ARE IN FORCE SO THAT WE MAY BETTER SERVE OUR PATIENT.
Please read and initial where indicated after each policy.

We require a 24-hour notice if you must cancel your appointment. Failure to do so will result in a $25.00 charge to your account. ________________ Patient/Parent Initial

There will be a $25.00 fee for all returned checks. ___________________ Patient/Parent Initial

Oral & Maxillofacial Surgeons of Northern Arizona Notice of Policy Practices is available upon request.
I would like a copy. ❐ Yes ❐ No
I would like to read a copy while I am here. ❐ Yes ❐ No

I understand that all services are payable at the time of service unless prior arrangements are made with the doctor. Any balance due past the 10th of the month may be subject to a finance charge computed at 2% per month. I agree to pay all costs and expenses incurred should this account be tuned over to an attorney, collection agency, or any action through the legal system for collection, including legal fees, collection agency fees, court costs and interest.

___________________________________ / ____ ________________________
Patient/Parent or Guardian Signature (Print / Full Signature) Date

I authorize the release of any medical or other information necessary to process my insurance claim.

____ ________________________
Patient/Parent or Guardian Signature Date

Release of Personal Health Information (PHI)
I authorize disclosure of PHI of any and all financial information to:

Name ____ Relationship ____
Address ____
Telephone ____

This authorization will be in effect for one year and can be revoked at anytime by me in writing.

Patient Signature ____ Date ___________________