FOOTHILLS ORAL SURGERY
THE WISDOM TEETH & DENTAL IMPLANT EXPERTS

All patients are required to read and **completely** fill out the patient and insurance information portion of this form.
All information will be kept confidential.

Patient Information

Patient's Legal Name _____ Nickname _____
Last First MI

Home # _____ Cell # _____ Work # _____

Email _____ Spouse's Name _____

Address _____
Street Address City State Zip

Patient's Date of Birth _____ Age _____ SS# _____

Full Time Student Y _____ N _____ Part Time Student Y _____ N _____ Where? _____

If under 18, Name of Parent or Responsible Legal Guardian _____

Parent's Address _____
Street Address City State Zip

Parent's Home # _____ Cell # _____

Employer _____

Emergency Contact _____ Phone # _____ Relationship to Patient _____

Whom may we thank for referring you? _____

Dentist _____ Orthodontist _____ Primary Physician _____

Family members who have been patients here _____

Insurance

Dental Insurance Information

Name of Dental Insurance _____ Ins Phone # _____

Policy Holder (who carries insurance) _____Relationship to Patient _____

Policy Holder Address _____

Policy Holder Phone # _____ Policy Holder Employer _____

Policy Holder SS # _____ Ins ID # _____ Group # _____

Policy Holder Date of Birth _____

Medical Insurance Information

Name of Medical Insurance _____ Ins Phone # _____

Policy Holder (who carries insurance) _____Relationship to Patient _____

Policy Holder Address _____

Policy Holder Phone # _____ Policy Holder Employer _____

Policy Holder SS # _____ Ins ID # _____ Group # _____

Policy Holder Date of Birth _____

My signature below acknowledges that I have completely read, understand and comply with the information given on this form. The information is true and accurate to the best of my knowledge and I understand that any information given falsely may affect my status of financial account with this office.

Patient Signature/Policy Holder Signature _____ Date _____

Secondary Insurance — See Back

Dental Insurance Information

Name of Medical Insurance _____ Ins Phone # _____

Policy Holder (who carries insurance) _____Relationship to Patient _____

Policy Holder Address _____

Policy Holder Phone # _____ Policy Holder Employer _____

Policy Holder SS # _____ Ins ID # _____ Group # _____

Policy Holder Date of Birth _____

Medical Insurance Information

Name of Dental Insurance _____ Ins Phone # _____

Policy Holder (who carries insurance) _____Relationship to Patient _____

Policy Holder Address _____

Policy Holder Phone # _____ Policy Holder Employer _____

Policy Holder SS # _____ Ins ID # _____ Group # _____

Policy Holder Date of Birth _____

HEALTH HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____ DATE _____

Answer all questions by checking No or Yes and underline the conditions that apply. **All responses are kept confidential**

❑ No ❑ Yes Are you in good health?
❑ No ❑ Yes Has there been any change in your general health in the past year?
Date of last physical exam_____
❑ No ❑ Yes Are you now under a physician's care for a particular problem?
Physician's Name_____
Phone Number_____
❑ No ❑ Yes Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe
_____
_____
Height_____ Weight_____ Age_____

DO YOU HAVE OR HAVE YOU EVER HAD: (UNDERLINE ALL THAT APPLY)

❑ No ❑ Yes Rheumatic Fever or Rheumatic Heart Disease?
❑ No ❑ Yes Congenital Heart Disease or Endocarditis?
❑ No ❑ Yes Heart Disease (Heart Attack, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Heart Valve, MVP)?
❑ No ❑ Yes Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?
If so, last attack_____
❑ No ❑ Yes Seizures, Convulsions, Epilepsy, Fainting or Dizziness?
❑ No ❑ Yes Psychiatric Treatment, Nervous Disorder, Breakdown?
❑ No ❑ Yes Bleeding Disorder, Anemia, Bleeding Tendency,
❑ No ❑ Yes Blood Transfusion? Do you bruise easily?
❑ No ❑ Yes Liver Disease (Jaundice, Hepatitis)?
❑ No ❑ Yes Kidney Disease?
❑ No ❑ Yes Diabetes?
❑ No ❑ Yes Thyroid Disease (Goiter)?
❑ No ❑ Yes Arthritis, Bone Disease, Osteoporosis?
❑ No ❑ Yes Stomach Ulcers or Colitis?
❑ No ❑ Yes Glaucoma?
❑ No ❑ Yes Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?
❑ No ❑ Yes Radiation (X-ray) treatment for Cancer?
❑ No ❑ Yes Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?
❑ No ❑ Yes Sinus or Nasal problems?
❑ No ❑ Yes Sleep Apnea, Snoring?
❑ No ❑ Yes Any disease, drug or transplant operation that has depressed your immune system?

ARE YOU USING ANY OF THE FOLLOWING: (UNDERLINE ALL THAT APPLY)

❑ No ❑ Yes Antibiotics?
❑ No ❑ Yes Anticoagulants (Blood Thinners)?
❑ No ❑ Yes Aspirin or drugs such as Motrin, Aleve, Ibuprofen?
❑ No ❑ Yes High Blood Pressure medications?
❑ No ❑ Yes Steroids (Cortisone, etc.)?
❑ No ❑ Yes Tranquilizers, Antidepressants?
❑ No ❑ Yes Insulin or Oral Anti-Diabetic drugs?
❑ No ❑ Yes Digitalis, Inderal, Nitroglycerin or other heart drug?
❑ No ❑ Yes Are you taking or *have you ever taken* Bisphosphonates (Fosamax, Actonel, Xgeva/Denosumab (Prolia), or Boniva for osteoporosis, or Aredia or Zometa for multiple myeloma, or other cancers)? How Long?_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: (UNDERLINE ALL THAT APPLY)

❑ No ❑ Yes Local Anesthesia (Novocain, etc.)?
❑ No ❑ Yes Penicillin or other antibiotics?
❑ No ❑ Yes Sedatives, Barbiturates?
❑ No ❑ Yes Aspirin or Ibuprofen?
❑ No ❑ Yes Codeine or other pain killers?
❑ No ❑ Yes Latex or Rubber Products?
❑ No ❑ Yes Other allergies or reactions? Please, list
_____
_____

PLEASE LIST (SEE BACK) ANY AND ALL MEDICATIONS TAKEN, INCLUDING PRESCRIPTION MEDICATIONS, HORMONAL REPLACEMENTS, OVER-THE-COUNTER MEDICATIONS, HERBAL OR HOLISTIC REMEDIES, VITAMINS OR MINERALS ON THE BACK.

❑ No ❑ Yes Do you smoke or chew Tobacco?
How much per day?_____
❑ No ❑ Yes Do you use Alcohol?
If so, how much?_____
❑ No ❑ Yes Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?
❑ No ❑ Yes Have you had any serious problems associated with any previous dental treatment?
❑ No ❑ Yes Have you or an immediate family member had any problem associated with anesthesia or IV's?
❑ No ❑ Yes Do you have any problems with IV's?
❑ No ❑ Yes Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
❑ No ❑ Yes Do you wish to talk to the doctor privately about anything?

FOR WOMEN ONLY

❑ No ❑ Yes Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?
❑ No ❑ Yes Are you nursing?

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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Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

_____ _____ _____ _____
Date Exceptions or changes Patient's Signature Doctor's Initials

_____ _____ _____ _____
Date Exceptions or changes Patient's Signature Doctor's Initials

MEDICATION NAME	MG	DOSAGE	WHEN TAKEN	WHO PRESCRIBES	DATE	INITIALS

MEDICATION UPDATE:

Date	Exceptions or Changes	Patient Signature	Doctor's Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Foothills Oral Surgery

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Drs. Darab, Richardson & Lybrand is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released:** Medical and/or Financial
☐ Voice Mail (Home or Cell)	☐ Other_____
☐ Spouse of patient _____ ☐ Parent(s) of patient_____ ☐ Other person (s) _____	
☐ Email communication-Provide email address _____	
For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication as selected.	
Photo will be taken for the patient's account.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient (if minor, Parent Signature) or Personal Representative*

*Description of Personal Representative's Authority (attach necessary documentation)

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.50 for each page, $10.00 minimum for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 13, 2003. If you request this account more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of you health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (your request will be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or be electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health of Human Services.

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:

Dr. David J. Darab
P. O. Box 2526
Hickory, NC 28603

828-322-1667

Fax: 828-324-5877

Notice of Privacy Practices

Foothills Oral Surgery

3452 Graystone Pl SE
Hickory, NC 28601
828-322-1667

701 S. Laurel St., Ste 2
Lincolnton, NC 28092
704-732-7477

1306 Davie Avenue
Statesville, NC 28677
704-873-6988

Visit our Website at www.omsdrs.com

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal law to maintain the privacy of your health information. We are also required to give you the 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 the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the 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 the 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 the 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 will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use and disclose your health information in connection with our 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, educational programs, accreditation, certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment.

Appointment Reminders: We may use or disclose your information to provide you with appointment reminders (such as voicemail messages, e-mail, postcards, or letters).

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 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 while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must 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 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 you care, of your location, your general condition, or death. If you are present, then prior to use or disclosure or your health information, we will provide you with an opportunity to object 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 improvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable references 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 your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health of safety of others.

Law Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Foothills Oral Surgery

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name: _____
Date of Birth: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature (if minor, Parent Signature) Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____ _____

Prepared By _____

Signature _____

Date _____