Arizona Center for Implant, Facial, and Oral Surgery

Patient Information

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

First Name_____ Middle Initial_____ Last Name_____

SS#_____ Date of Birth_____ Age_____ ☐ Male ☐ Female

Address_____ Apt#_____ City_____ State_____ Zip_____

Home Phone (____) _____ Cell Phone (____) _____ Full Time student? **Yes / No**

Employer_____ Email_____

Name of parent or legal guardian accompanying minor_____
FIRST NAME LAST NAME

DOB_____ SS#_____ DL#_____ State_____

Address_____ Apt#_____ City_____ State_____ Zip_____

Relationship to minor_____ Home Phone(____) _____ Cell Phone(____) _____

***** For children under 18 years of age, the legal guardian or parent accompanying the child to this appointment is deemed the responsible party for the payment on this account.*****

Emergency Contact_____ Phone (____) _____ Relationship_____

I authorize the doctors or staff to discuss my care and/or treatment with my primary emergency contact or person listed above._____(initial)

Referred by_____ **Patient's Dentist**_____
FIRST NAME LAST NAME FIRST NAME LAST NAME

Primary Dental Insurance

Insurance Company_____ Insurance Phone (____) _____

Insured_____ SS/ID#_____ DOB_____
FIRST NAME LAST NAME

Insured Address_____ Apt#_____ City_____ State_____ Zip_____

Employer_____ Group #_____ Relationship to Patient_____

Secondary Dental Insurance

Insurance Company_____ Insurance Phone (____) _____

Insured_____ SS/ID#_____ DOB_____
FIRST NAME LAST NAME

Insured Address_____ Apt#_____ City_____ State_____ Zip_____

Employer_____ Group#_____ Relationship to Patient_____

X_____ _____
Patient Signature (or parent/guardian, if patient is a minor) Date

Arizona Center for Implant, Facial, and Oral Surgery

FINANCIAL POLICY AND PRACTICE NOTICES

Privacy Practice Acknowledgement for All Patients:

_____(Please Initial) **HIPAA Notice**: You have the right to read our Notice of Privacy Practices before you decide to initial this section. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices to follow federal/state guidelines. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will NOT affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Financial Agreement:

_____(Please Initial) I understand payment (including co-payment if billing insurance for covered procedure) is due at the time services are rendered. Cash, Debit, Credit Cards (subject to 1.5% processing fee) Money Order, Care Credit, and Checks are accepted methods of payment.

_____(Please Initial) I understand that upon failure to pay for services rendered, my account (including all personal information) may be sent to a collection agency. An additional collection agency fee of 30% will be applied to the account's outstanding balance.

For Patients with Insurance Only:

_____(Please Initial) ASSIGNMENT AND RELEASE: I hereby authorize payment to **Arizona Center for Implant, Facial and Oral Surgery** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions. I further authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason my behalf, should the need arise.

_____(Please Initial) If there is insurance, the balance is due within 60 days from the date of service or when insurance pays, whichever is first. Pursuant to the Federal Consumer Credit Protection Act, we disclose that no interest charge will be applied if this agreement is adhered to. If the terms of this agreement are not met, interest charges of 1.5% per month is to be adhered to the remaining balance (18% per year) in addition to the entire balance becoming due.

For Medicare Beneficiaries Only:

_____(Please Initial) I have reviewed agree to the terms of the Private Contract (dated 7/2014) and understand Medicare will not be billed for any services rendered.

_____ _____

Patient Signature (OR legal representative; parent/guardian, if patient is a minor) Date

Arizona Center for Implant, Facial, and Oral Surgery

Patient Name:_____

Pharmacy:_____Phone:( )_____

Family Physician:_____
FIRST NAME LAST NAME

Phone:( )_____

Specialist:_____
FIRST NAME LAST NAME

Answer all questions by circling Yes or No

1. Are you in good health? Yes or No

2. Has there been any change in your health history in the last year? Yes or No

3. Date of last physical exam_____

4. Are you now under a physician's care for any particular illness? Yes or No

5. Have you **ever** had any serious illness, operations, or hospitalizations? If so please describe.

6. Height:_____Weight:_____

7. Do you have or have ever had any of the following?

Rheumatic Fever	Yes	or	No
Rheumatic heart disease	Yes	or	No
Congenital heart disease	Yes	or	No
Heart attack	Yes	or	No
Heart trouble	Yes	or	No
Heart murmur	Yes	or	No
Coronary artery disease	Yes	or	No
Angina	Yes	or	No
High blood pressure	Yes	or	No
Stroke	Yes	or	No
Palpitations	Yes	or	No
Heart surgery	Yes	or	No
Pacemaker	Yes	or	No
MVP (mitral valve prolapse)	Yes	or	No
Asthma	Yes	or	No
Emphysema	Yes	or	No
Chronic cough	Yes	or	No
Bronchitis	Yes	or	No
Pneumonia	Yes	or	No
Tuberculosis	Yes	or	No
Shortness of breath	Yes	or	No
Chest pain	Yes	or	No
Severe coughing	Yes	or	No
Seizures	Yes	or	No
Convulsions	Yes	or	No
Epilepsy	Yes	or	No
Fainting	Yes	or	No
Dizziness	Yes	or	No
Bleeding disorder	Yes	or	No
Anemia	Yes	or	No
Bleeding tendency	Yes	or	No
Blood transfusion	Yes	or	No
Do you bruise easily?	Yes	or	No
Jaundice	Yes	or	No
Hepatitis	Yes	or	No
Kidney disease	Yes	or	No
Diabetes	Yes	or	No
Thyroid Disease	Yes	or	No
Arthritis	Yes	or	No
Stomach ulcers or colitis	Yes	or	No
COPD	Yes	or	No
Glaucoma	Yes	or	No
Implants anywhere in body	Yes	or	No
Radiation or chemotherapy for cancer	Yes	or	No

8. ARE YOU USING ANY OF THE FOLLOWING?

Antibiotics	Yes	or	No
Blood thinners	Yes	or	No
Aspirin	Yes	or	No
Motrin	Yes	or	No
Aleve	Yes	or	No
Ibuprofen	Yes	or	No
High blood pressure meds	Yes	or	No
Steroids (cortisone, ect.)	Yes	or	No
Tranquilizers	Yes	or	No
Insulin or Oral anti-diabetic drugs	Yes	or	No
Nitroglycerine	Yes	or	No
Other heart drugs	Yes	or	No
Bisphosphonates (Fosamax, Reclast, Boniva, Zometa, or other bone strengtheners)	Yes	or	No
Cholesterol Meds	Yes	or	No

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Please list any and all medications taken, including prescriptions, over-the-counter medications, herbal, or holistic remedies, vitamins, or minerals:

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

Local anesthesia (Novocain, etc)	Yes	or	No
Penicillin or other antibiotics	Yes	or	No
Sedatives	Yes	or	No
Barbiturates	Yes	or	No
Aspirin or Ibuprofen	Yes	or	No
Codeine or other pain killers	Yes	or	No
Latex or rubber products	Yes	or	No

Other allergies or reactions? Please list:

10. Do you smoke or chew tobacco? Yes or No
If so, how much per day? _____

11. Is there any past history of alcohol or chemical use? Yes or No

12. Have you or any immediate family member had any dependency or emotional disorder that may affect the care we provide to you? Yes or No

13. Have you or any immediate family member had problems associated with intravenous anesthesia? Yes or No

14. Do you have any disease, condition, or other problem not listed so far that you believe the doctor should be aware of? Yes or No

15. Do you wish to talk to the doctor privately about anything? Yes or No

16. FOR WOMEN ONLY:

Are you pregnant, or is there **any chance** you might be pregnant? Yes or No

Are you nursing? Yes or No

If you are using oral contraceptives, it is important to 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, after the course of antibiotics or other medications is complete. Please consult 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 the doctor.**

X_____**Date:**_____

Patient Signature (or person completing the health history)

X_____**Date:**_____

Doctor Signature (upon reviewing health history)

Updates Only:

I have reviewed my medical history form and everything is correct and/or I have noted any changes.

X_____Date:_____

Arizona Center For Implant, Facial and Oral Surgery

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 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 **Arizona Center for Implant, Facial and Oral Surgery 18301 N. 79th Avenue, Bldg. G, Suite 185, Glendale, Arizona 85308 623-931-9197,** in person or in writing, during normal hours. We 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; and accommodate your 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 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 **Arizona Center for Implant, Facial and Oral Surgery 18301 N. 79th Avenue, Bldg. G, Suite 185, Glendale, Arizona 85308 623-931-9197.**
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 **Arizona Center for Implant, Facial and Oral Surgery.** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is **Arizona Center for Implant, Facial and Oral Surgery 18301 N. 79th Avenue, Bldg. G, Suite 185, Glendale, Arizona 85308 623-931-9197, manager@azctr4implants.com.**

- 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 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.

OPTIONAL/ADDITIONAL Uses and Disclosures

The following are segments of the Notice of Privacy Practices that may not be used by the general OMS practice. If your Notice of Privacy would need to incorporate any of these items, we have provided model language. An example would be: If your practice participates with drug research, then you would need to include the first item listed below in your Notice of Privacy Practices.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief: We may use and disclose your protected health information to assist in disaster relief efforts.

Funeral Directors/Coroners: We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide you with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

Fund Raising: We may contact you as part of a fund raising effort.

For Specialized Governmental Functions: We may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Effective Date: On or after April 14, 2003

Safety Protocols and Screening Questionnaire for Elective Oral Surgery Procedures

I am informed that the Governor of Arizona has allowed elective oral surgery procedures to commence as of May 1st, 2020. I am informed that this office follows all ADA (American Dental Association) and OSHA (Occupational Safety Health Association) guidelines to ensure safety of our patients and office staff.

I confirm that I am not presenting any of the following symptoms below:

- FEVER
- SHORTNESS OF BREATH
- DRY COUGH
- SORE THROAT
- RUNNY NOSE

- I further verify that I have not traveled outside the USA in the past 14 days.
- I verify that I have not traveled domestically within the United States by commercial airplane, bus or train within the past 14 days.
- I verify I have not knowingly come into contact with individuals who have symptoms or have traveled as stated above.
- I understand that I may be required to seek medical evaluation prior to oral surgery procedures if any of the symptoms listed above and/or travel history pertains to me.

Name: _____ Date: _____