Chart #_____

Dr. Ted Fields Oral Surgery

Office Goals: Our goal is to provide the highest caliber of oral surgery in a professional but carring manner that makes our patients feel welcome and comfortable. Please let us know if you have special concerns or are nervous about receiving dental treatment. We will take extra measures in such cases to put you at ease.

PATIENT INFORMATION

Patient's Legal Name: _____ **Today's Date:** _____/____/_____
Last Name First Name Middle

Date of Birth: _____/_____/_____ Age: _____ Height: _____'_____" Weight: _____ lbs.

Sex: ☐ Male ☐ Female Primary Language: _____

Address: _____
Street & Apartment/Suite City State ZIP

Phone	**Privacy**	**Emergency Contact**	**Can we discuss your care?**
Home: (_____) _____ - _____	☐	Name: _____	Yes ☐ No ☐
Work: (_____) _____ - _____	☐	Relationship: _____	Yes ☐ No ☐
Cell: (_____) _____ - _____	☐	Home: (_____) _____ - _____	Yes ☐ No ☐
Fax: (_____) _____ - _____	☐	Work: (_____) _____ - _____	Yes ☐ No ☐

Email: _____ Preferred Method of Contact: _____

May we email correspondence? Yes ☐ No ☐

Occupation/Employer or School: _____

☐ Full Time Employment ☐ Part Time Employment

☐ Full Time Student ☐ Part Time Student

☐ Retired ☐ Other

Tell us what procedures you are interested in? _____

Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Primary Insured

Name of Primary Insured Person: _____ Is insured a patient? ☐ Yes ☐ No

Insured's Date of Birth: _____/_____/_____ Patient's Relationship to Insured: Self _____ Spouse _____ Child _____

Insured's Address (if different): _____

Insured's Employer Name: _____

Dental Insurance Carrier: _____

Group #: _____ Social Security or I.D. #: _____

Carrier Phone # : (_____) _____ - _____

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule 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 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 (please check all that apply):

☐ Home Telephone _____

_____

___ O.K. to leave message with detailed information

___ Leave message with call back number only

☐ Cell Telephone

___ O.K. to leave message with details information

___ Leave message with call back number only

☐ Written Communication

___ O.K. to mail to my home address

___ O.K. to mail to my work/office address

___ O.K. to fax to number indicated

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

___ Spouse

___ Parent

___ Child

___ None

___ Other

(specify)_____

_____ _____

Signature of patient, parent or guardian Date:

PAST MEDICAL HISTORY

Please check if you have, or ever had any of the following conditions: ☐ **None**

Cardiovascular

☐ Anemia

☐ Angina / Chest pain

☐ Arrhythmia

☐ Congestive heart failure

☐ Heart attack

☐ Heart murmur

☐ High blood pressure

☐ High cholesterol

☐ Heart valve disorder

☐ Pacemaker / Stent

☐ Rheumatic heart disease

Respiratory

☐ Asthma / Bronchitis

☐ COPD / Emphysema

☐ Pneumonia

☐ Tuberculosis

☐ Sinus Problems

Gastro-intestinal

☐ Liver disease

☐ GERD

☐ Hernia

☐ Hepatitis A, B, C

☐ Peptic ulcers

Blood

☐ Bleeding disorder

☐ Blood transfusion

☐ DVT / Blood clots / Pulmonary embolism

Neurologic

☐ Epilepsy

☐ Migraines

☐ Paralysis

☐ Stroke / TIA

Mental Health

☐ Alcohol / Drug dependency

☐ Anorexia / Bulimia

☐ Depression

☐ Psychiatric care

☐ Suicide attempt

Skin / Skeletal

☐ Jaundice

☐ Artificial Joints

☐ Arthritis

☐ Gout

☐ Osteoporosis / Osteopenia

Immune / Infection

☐ AIDS/ HIV

☐ Herpes / Fever

☐ Immune problem

☐ Venereal disease

☐ MRSA / VRE

Endocrine

☐ Diabetes

☐ Thyroid disorder

Other

☐ Glaucoma

☐ Kidney disorders

☐ Transplant

Do you have any type of cancer? _____

Radiation? ☐ Yes ☐ No If so, when did treatment begin or when will it begin?

_____

Impairments? _____

Are you being treated for any other illness at this time? ☐ **Yes** ☐ No

Illness(s)_____

Name and Phone of Physician(s):

_____

_____

Date of Last Physical: _____ / _____ / _____ Results:

_____

Name: _____ **Age:** _____ **Date:** _____/_____/_____

Have you ever had **SURGERY**? ☐ Yes ☐ No If yes, please list:

Have you, or a family member ever had a problem with anesthesia? ☐ Yes ☐ No – If yes, please explain:

_____

Have you been diagnosed with sleep disorder / sleep apnea? ☐ Yes ☐ No

Do you use a C-Pap Machine for your sleep disorder? ☐ Yes ☐ No

---

Do you have **ALLERGIES**? ☐ Yes ☐ No If yes, please name of drug and reaction:

☐ Penicillin ☐ Antibiotics _____	☐ Food products ☐ **Eggs** _____
☐ Codeine ☐ Pain killers _____	☐ Latex
☐ Over the counter pain meds _____ Aspirin, Naproxen, Ibuprofen, Acetaminophen	☐ Other _____

FAMILY HISTORY (Only list blood related relatives.) ☐ **None**

☐ Diabetes		☐ Blood Clots		☐ High Blood Pressure	
☐ Stroke		☐ Heart Disease		☐ Cancer / Type	
☐ Other					

LIST ALL MEDICATIONS YOU ARE TAKING WITH NAME AND DOSAGE: ☐ No Meds

		☐ Antibiotics	☐ Chemotherapy
		☐ Aspirin / NSAID's	☐ Antidepressants
		☐ Blood thinners	☐ Steroids
		☐ Vitamins / Supplements	☐ Herbals / Homeopathic
		☐ Bisphosphonates	

Name: _____ **Age:** _____ **Date:** _____/_____/_____

PHARMACY NAME & NUMBER:

Pharmacy Name: _____ **Phone number:** _____

Address or Location _____

Are you taking or have you ever taken recreational drugs? ☐ Yes ☐ No What type?

_____

Please give more details:

_____

Do you smoke? ☐ Yes ☐ No Quit? _____ How much? _____

Do you drink? ☐ Yes ☐ No ☐ Socially ☐ Occasionally ☐ Moderately

WOMENS HEALTH **Are you pregnant, or could you possibly be pregnant? ☐ Yes ☐ No**

REVIEW OF SYMPTOMS **Please CIRCLE the following symptoms you have had recently. ☐ No Symptoms**

General	**Fatigue, fever, chills, sweats, sleep disturbance. Recent weight gain or loss.**
Eyes, Ears, Nose & Throat	**Blindness, blurred vision, cataracts, contact lenses, double vision, dry eyes, eye irritation, eye pain, excessive tearing, red eyes, sensitivity to light, visual changes, ear discharge, difficulty breathing through nose, dizziness, hearing loss, ringing in the ears, chronic nasal congestion, nose bleeds, loss of sense of smell, past nasal injury, sinus problems ulcer/sore, difficult swallowing, hoarseness, snoring.**
Cardiovascular	**Chest pain, congestive heart failure, irregular / rapid heartbeat, heart attack, low blood pressure, mitral valve relapses / need for antibiotics for dental procedures, palpitations / skipped beats, poor circulation, rheumatic fever, varicose veins.**
Respiratory	**Bronchitis, bloody cough, shortness of breath, pneumonia recent cough, wheezing, tuberculosis**
Gastrointestinal	**Bloating, blood in vomit / stools, changes in appetite, crohn's disease, constipation, diarrhea, gastritis / reflux, hepatitis / jaundice, irritable bowel syndrome, nausea / vomiting, peptic ulcers, ulcerative colitis**
Musculoskeletal	**Arthritis, difficulty walking, extremity pain, injuries, joint pain, leg cramps, lupus erythematosus, rheumatoid arthritis, unusual muscle weakness, swelling.**
Neurologic	**Dizziness / fainting, numbness, migraines / headaches, seizures / epilepsy, sensory loss, stroke, weakness / loss of balance.**
Heme / Immunologic	**Bleeding gums, blood clot / clotting disorder, blood transfusion, easy bruising, HIV complications, MRSA / VRE infections, sickle cell anemia, swollen lymph nodes.**
Endocrine / Hormonal	**Adrenal disorders, labile blood glucose levels, neuropathy, steroid use, thyroid symptoms**
Psychiatric	**Alcoholism, anxiety, depression, drug abuse, schizophrenia.**

Name: _____ **Age:** _____ **Date:** _____/_____/_____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? ☐ Yes ☐ No If yes, please explain: _____

_____

Do you wish to talk to the doctor privately about anything? ☐ Yes ☐ No

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X_____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____

Printed Name of Patient, Parent, Guardian or Personal Representative **Date**

_____

Witness Signature **Date**

_____

Doctor's Signature **Date**

Doctors Use Only (Additional Notes):

Office and Financial Policies

Welcome to the office of Dr. Ted Fields. We are happy to have you as a patient. Please take a moment to read the following office and financial policies as they were designed to help our office better serve you. If you have any questions about this policy, please do not hesitate to ask. We are here to work with you and make your visit and/or surgery experience the best possible.

Punctuality – We ask that you arrive on time for your appointments. We also realize that all our patients are busy as well, and we make every attempt to adhere to our schedule. However, the nature of dentistry and oral surgery is that, on occasion, a procedure can take longer than anticipated because each patient is unique. In addition, our policy is to always make room for established patients when they have emergencies, and this can unexpectedly delay our schedule. We ask for your patience in these cases, and in return, we will give you our undivided attention during your appointment.

Children – We request that a parent be present during the appointment of any child younger than 18 years old. On occasion, it is necessary to deviate from the treatment which was originally planned, and parental consent is required to proceed.

Cancellation fees – A fee or payment in advance of any future services will be assessed to any patient who does not show up for an appointment, or who cancels an appointment with less than 24-hour notice. At minimum, the fee will be equal to $50 per hour of time for which the appointment was scheduled. In addition, we will terminate our relationship with patients who, for two (2) consecutive appointments, cancel with less than 24 hours or fail to show up.

Record Transfer Fee – A fee of $35 may be charged (for material and staff time) to duplicate and transfer patient x-rays/records to another dental office.

Insurance – Although we are out-of-network with all dental insurance carriers, as well as Medicare, as a courtesy to our patients with insurance, we will file claims on your behalf. Reimbursement will be made to the primary policy holder.

Payment and Consent for Services

Payment is due at the time services are rendered. A Non-Refundable $500 booking fee is required in order to secure a procedure date for procedures exceeding $1,000 in treatment. Personal checks, credit cards and Care Credit are acceptable forms of payment. Please come prepared to pay, as we cannot bill you and collect payment at a later time. This practice depends upon reimbursement form patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental and oral surgery services furnished are charged directly to the patient and that he or she is personally responsible for payment of all services. This office will prepare and submit the patient's insurance forms or assist in making collections from insurance companies. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

Therefore, in consideration for the professional services rendered at your request by Dr. Ted Fields, by signing this form, you agree to pay the reasonable value of services to Dr. Ted Fields, at the time services are rendered, or within five (5) days of billing, if billing is extended. You further agree that a waiver of any breach at any time or condition shall not constitute a waiver of any further term or condition and agree to pay all costs and reasonable attorney fees if suit be instituted.

I understand that a fee estimate listed for dental and oral surgery care can only be extended for a period of 6 months from the date of the patient examination.

I authorize the use of all images for educational and professional purposes.

I give my permission to you and your assignee, to telephone me at home or at my work to discuss matter related to this form.

My signature below signifies that I understand my responsibility regarding charges incurred at Dr. Ted Fields Oral & Maxillofacial Surgery and agree with the financial policy.

Name (printed) _____ **Date:** _____/_____/_____

Name (signature) _____ **Date:** _____/_____/_____

Employee witness: _____ **Date:** _____/_____/_____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of you questions regarding the contents of our Notice have been answered.

Patient/Guardian Name: _____ **Date:** _____/_____/_____

CONSENT FOR RELEASE OF RECORDS

By signing below you consent to the release of your records to your current dentist, physician, or any doctors that are recommended to participate in your follow up care. Should you request that your records be shared with another office this is your consent to release the records to that office.

Patient Name_____
(printed)

Patient Name _____ **DATE**_____
Signature

NOTICE OF PRIVACY 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 IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include tooth extraction services.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and insurance review. An example of this would be sending a bill for your visit to your insurance company for payment

- Health care operations include the business aspect of running our office, such as conducting quality assessment and improvement activities, management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For More Information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619 – 0257
Toll Free: 1-877-696-6775