Angelo Oral Surgery & Dental Implants

Patient Information

Patient's Full Name_____ Male/Female Single/Married

Social Security Number_____ Date of Birth_____ Age_____ Student Y/N

Mailing Address_____(city)_____(state)_____(zip)_____

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Employer_____ Occupation _____ Email_____

Have you or a family member ever been a patient of our Practice, If so, who:_____

Who referred you to this office? (circle) Friend Physician Dentist Orthodontist Other:_____

General Dentist_____ Orthodontist_____ Physician_____

Person Financially Responsible For Account

Full Name_____ Date of Birth_____ Social_____

Employer_____ Employer Phone (____)_____

Email_____ Relationship to Patient_____

Primary Dental Insurance

Insurance Company_____

Address_____

Phone_____ Group#_____

Subscriber Name_____

Social Security #_____ DOB_____

ID#_____

Relationship to Patient_____

Employer:_____

Primary Medical Insurance

Insurance Company_____

Address_____

Phone_____ Group#_____

Subscriber Name_____

ID #_____ DOB_____

Employer_____

Relationship to Patient_____

Secondary Insurance

Insurance Company_____ Address_____ Phone_____

Subscriber Name_____ DOB_____ SSN_____ Employer_____

Thank you for choosing our office as your oral surgery health care provider This statement is to inform you of your financial policy. We are committed to providing you with the highest quality dental care so that you may fully attain optimum oral health.

You are responsible for brining your insurance card(s) to your consultation appointment. If we do not have your insurance information at the time of surgery, we may not be able to bill your insurance company. The undersigned patient of Angelo Oral and Maxillofacial Surgery, Ryan L Montgomery DDS, MD for and in considerations of the services to be rendered for me or at my request, does hereby ASSIGN, all of my right, titles and interest in and to any payment or recovery which I may receive from my own first party insurance or from third party, which may be related to or arising out of these services, to make that payment directly to Angelo Oral and Maxillofacial Surgery, Ryan L Montgomery DDS, MD. By signing below I authorize release of any and all necessary information to my insurance provider to generate payment and for this practice to receive payment directly. I understand and agree that I am financially responsible for the balance on my account regardless of insurance status. If this amount should become delinquent I understand that i will be held responsible for any and all costs/fees/additional charges from collection efforts.

Sign X_____ Date _____

Angelo Oral Surgery & Dental Implants

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

The undersigned acknowledges receipt of a copy of the currently effective notice of privacy practices for this health care facility. My signature will also serve as a PHI document release should I request treatment or radiographs be sent to another facility in the future.

_____

(Print Patient Name)

_____ _____

(Patient/Legal Guardian Signature) (Date)

Please list any other parties that can have access to your health information:

Name_____ Relationship_____ Phone# _____

Name_____ Relationship_____ Phone# _____

Name_____ Relationship_____ Phone# _____

I authorize contact from this office to confirm appointments, treatment & billing information via: (please circle)

cell phone home phone work phone email all of the above

Health History Form

Patient's Name _____ Date of Birth ____/____/____

Gender: Male / Female Height: _____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: _____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/____/____

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why? _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No
If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

FAMILY MEDICAL HISTORY

Do you have a family history of heart disease, diabetes, bleeding problems, anesthetic problems?

FEMALE PATIENTS

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

Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

MEDICATIONS

Please list all medications

Have you ever taken bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? (Fosamax, Actonel, Boniva, aredia, prolia, zometa, Reclast) If yes, list drugs used and time of use.

ALLERGIES

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

Latex? Yes No

Other – Please list all drug allergies

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No
Emotional disorders? Yes No
Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? _____
Marijuana? Yes No How often? _____
Recreational drugs? Yes No How often? _____

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

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

_____
Signature of patient, parent, guardian (Date)

_____
Printed name of patient, parent, guardian (Relationship

HEALTH HISTORY UPDATE

Date Comments

Doctor's Comments

ASA I II III IV

MP 1 2 3 4

CV _____

Resp _____

Ryan L Montgomery, DDS, MD

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 carefully.
With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information and purposes of treatment, payment, and health care operations. Protected health information (PHI) is 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 the 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 and other businesses as necessary to obtain these services.

Your Health Information Rights

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

- Ask someone who has medical power of attorney or your legal guardian, to exercise your rights and make choices about your health information.
- Request a restriction on certain uses and 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.
- Obtain a copy of your paper or electronic record.
- Appeal a denial of access to your PHI in certain circumstances.
- 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 information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law.
- Request that communication of your health information be made by alternate means or at an alternate location by delivering the request in writing to our office.
- Elect to opt out of receiving further communications to raise funds for the practice.
- 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 our office at 325-944-3565, 3012 Green Meadow Dr., San Angelo, TX 76904, 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.
- Accommodate your reasonable requests regarding methods to communicate health information with you.
- We will never share your information (for marketing purposes, sharing of psychotherapy notes) without your written permission 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 PHI 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 our office at 325-944-3565.

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 the office. You may also file a complaint by 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 of receiving treatment from the practice.

We cannot and will not retaliate against you for filing a complaint with HHS.

Other disclosures and uses

Notification- Unless you object, we may use or disclose your PHI to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your general condition or death.

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

FDA- We may disclose to the FDA your PHI 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 WC, we may disclose your PHI to the extent necessary to comply with the laws relating to workers compensation.

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

Abuse and Neglect- We may disclose your PHI to public authorities as allowed by law to report abuse or neglect.

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

Law Enforcement- We may disclose your PHI 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 in the custody of law enforcement.

Health Oversight- Federal law allows us to release your PHI to appropriate health oversight agencies for health oversight activities.

Judicial/Admin Proceedings- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by proper court order.

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

Website- this notice will be on the website- www.angelooralsurgery.com