Village
Oral & Implant
SURGERY

Thank you for choosing Village Oral & Implant Surgery

IN ORDER FOR US TO PROPERLY SERVE YOU, PLEASE PROVIDE THE FOLLOWING INFORMATION.

PRINT CLEARLY AND LEAVE NO BLANKS.

PATIENT NAME:_____ DATE OF BIRTH:_____DATE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE: (H)_____(W)_____(C)_____

BEST TIME TO CONTACT:_____ PREFERRED WAY OF CONTACT:_____

EMAIL ADDRESS:_____

DRIVER'S LICENSE#:_____ STATE ISSUED:_____

SOCIAL SECURITY NUMBER:_____-_____-_____ PATIENT MARITAL STATUS: **S M D W**

IF PATIENT IS A CHILD, WHO MAY AUTHORIZE TREATMENT:_____

RELATIONSHIP TO PATIENT:_____

EMERGENCY CONTACT NAME:_____

PHONE:_____RELATIONSHIP:_____

PREFFERED PHARMACY:_____ LOCATION:_____

IS PT CURRENTLY IN PAIN? **YES NO** PLEASE RATE PAIN LEVEL ON A SCALE OF 1-10(10 BEING HIGHEST)_____

PATIENT INFORMATION. IF PATIENT IS CHILD, PARENT/GAURDIAN PLEASE FILL IN WITH YOUR INFORMATION:

EMPLOYER:_____PHONE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

DO YOU HAVE INSURANCE: (PLEASE CIRCLE ONE) **YES NO**

IF NO HOW WILL YOU PAY FOR TODAY? **CASH CHECK CREDIT CARD**

REFERRING DENTIST?_____

WHO IS YOUR REGULAR DENTIST?_____

INSURANCE COMPANIES REQUIRE THE BELOW WHEN FILING A CLAIM

DENTAL INSURANCE INFORMATION

PRIMARY INSURED:_____ RELATIONSHIP TO PATIENT:_____

Subscriber's SOCIAL SECURITY #:_____-_____-_____ Subscriber DATE OF BIRTH:_____

INSURANCE CO. NAME:_____ PHONE:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____STATE:_____ ZIP:_____

POLICY#:_____ GROUP ID#:_____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURED:_____ RELATIONSHIP TO PATIENT:_____

Subscriber's SOCIAL SECURITY #:_____-_____-_____ Subscriber DATE OF BIRTH:_____

INSURANCE CO. NAME:_____ PHONE:_____

INSURANCE COMPANY ADDRESS:_____

CITY:_____STATE:_____ ZIP:_____

POLICY#:_____ GROUP ID#:_____

I AUTHORIZE VILLAGE ORAL & IMPLANT SURGERY AND ANY EMPLOYEE ASSOCIATE WITH MY TREATMENT THE RIGHT TO SHARE PICTURES OF MY TREATMENT WITH REFERRING DOCTORS AS WELL AS TO USE AS A POTENTIAL SAMPLE OF BEFORE AND AFTER PROCEDURES ON THEIR WEBSITE OR FOR PUBLICATION AND YOU WILL REMAIN ANONYMOUS IN ALL PUBLIC PUBLICATIONS.

_____ _____

SIGNATURE OF PATIENT, PARENT OR LEGAL GAURDIAN **DATE**

I AUTHORIZE ANY EMPLOYEE OF VILLAGE ORAL & IMPLANT SURGERY INVOLVED WITH MY CARE TO DISCUSS MEDICAL AND/OR BILLING INFORMATION WITH THE FOLLOWING:

NAME:_____**RELATIONSHIP:**_____

I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTHCARE TO EXPEDITE INSURANCE PAYMENT. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE AND UNDERSTANT THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE CONVERAGE.

_____ _____

SIGNATURE OF PATIENT, PARENT OR LEGAL GAURDIAN **DATE**

Village Oral & Implant SURGERY

MEDICAL HISTORY FORM

Name:_____

Date of Birth: _____ **Sex: M / F** **Height:**_____ **Weight:** _____

For the following questions, circle yes or no, whichever applies.
Your answers are for our records only and will be kept confidential.

Chief Dental Complaint: _____

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8. Are you taking **or** have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia) ? ..... Yes No
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes No
   If so, please list: _____
10. Do you have or have you had any of the following diseases or problems?
    - Damaged heart valves, artificial valves or heart murmur ..... Yes No
    - Rheumatic Heart Disease ..... Yes No
    - Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
    - Chest pain upon exertion? ..... Yes No
    - Shortness of breath after mild exercise? ..... Yes No
    - Do your ankles swell? ..... Yes No
    - Allergies ..... Yes No
    - Sinus trouble ..... Yes No
    - Asthma or hay fever ..... Yes No
    - Fainting spells or seizures ..... Yes No
    - Diabetes ..... Yes No
    - Hepatitis, jaundice or liver disease ..... Yes No
    - Frequent or recurring mouth sores ..... Yes No
    - Thyroid problems ..... Yes No
    - Respiratory problems, emphysema, bronchitis, etc. ..... Yes No

Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
Osteoporosis ..... Yes No
Stomach ulcer or hyperacidity ..... Yes No
Kidney trouble ..... Yes No
Tuberculosis ..... Yes No
Persistent cough or cough that produces blood ..... Yes No
Persistent swollen neck glands ..... Yes No
Low blood pressure ..... Yes No
Epilepsy or neurological disorder ..... Yes No
Cancer ..... Yes No
Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

11. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
15. Are you allergic to or have you had a reaction to:

Local anesthetics ..... Yes No
Penicillin or antibiotics ..... Yes No
Sulfa drugs ..... Yes No
Barbiturates or sleeping pills ..... Yes No
Aspirin ..... Yes No
Iodine ..... Yes No
Codeine or other narcotics ..... Yes No
Latex or rubber products ..... Yes No
Other ..... Yes No

16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain:_____
    _____
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain:_____
18. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder ..... Yes No
20. Are you wearing contact lenses? ..... Yes No
21. Are you wearing removable dental appliances? ..... Yes No
22. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

20. Are you pregnant or trying to become pregnant ..... Yes No
21. Do you have problems associated with your menstrual period? ..... Yes No
22. Are you nursing? ..... Yes No
23. Are you taking birth control pills? ..... Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

_____ _____

Signature (Patient or responsible party) **Date**

VILLAGE ORAL & IMPLANT OFFICE AND FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy.

Payment is due at the time service is provided. We accept cash, personal checks, cashier's checks, money orders, Visa, Mastercard, Discover and Care Credit. Returned checks will be subject to additional fees. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance.

As a courtesy to you we will help you process all your insurance claims. We ask that you pay the deductible and co-payment, which is the **estimated** amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an **estimate** and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process. A finance charge will be imposed on those charges not paid in full within 90days of the treatment was rendered. The finance charge is a periodic rate of 1.5% per month (18% annually).

Separated & Divorced Couples with Dependent Children: It is the policy of this office to bill the parent that brings the children in for their dental treatment. Please make arrangements for payment from an ex-spouse before dental treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

All Patients must provide an **ID Card** & **Insurance Card** (if applicable) to be copied at the time of the appointment. We also require home and work telephone numbers, as well as a contact number to use in case of emergency.

Cancellation & Late Policy: Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We maintain a very strict schedule and must insist that appointment times be respected. For cancellation we require 48 hours advanced notice otherwise a $75 cancellation fee will be issued. An answer machine is available for messages left after business hours. Three missed appointments may result in dismissal as a patient. We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies.

Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

_____ _____

Signature (Patient or responsible party) **Date**

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 (PHI) 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:

- 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 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 you be allowed to inspect your health record and billing record - you may exercise this right by delivering the request in writing to our office;
- Obtain a copy of your paper or electronic record.
- 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 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 **[insert name of designated staff member, phone number, or address],** in person or in writing, during normal hours. **S[he]** 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, sale of your information, 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 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 **[insert name, title, and telephone number of internal contact person].**

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 **[list internal staff member.]** 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 **[insert street and e-mail addresses.]**
- 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 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 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.

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.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: [Insert effective date of the Notice]

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ ___ _____ _____

Signature (Patient or responsible party) Date