James B. Troxell, D.D.S.,M.S.
Oral and Maxillofacial Surgery

Welcome

Thank you for giving us the opportunity to care for you. To help us provide the highest level of care, please take a few moments to fill out the information below as accurately as possible.

PATIENT INFORMATION

DATE _____

NAME:_____ BIRTHDATE:_____
Last First M.I. Nickname

□ Male □ Female □ Single □ Married □ Widowed □ Divorced □ Separated

STREET ADDRESS:_____

CITY: _____ STATE:_____ ZIP:_____

HOME PHONE: (____)_____Message OK ☐ CELL PHONE (____)_____ Message OK ☐

EMAIL _____ Message OK ☐

OCCUPATION / SCHOOL (IF STUDENT):_____ GRADE: _____

EMPLOYER: _____BUSINESS PHONE: _____ Message OK ☐

WHO REFERRED YOU TO OUR OFFICE?_____

HAVE YOU OR ANY OTHER FAMILY MEMBER
BEEN TREATED IN OUR OFFICE? □ NO □ YES (Please list)_____

CONTACT INFORMATION: Contact/Relationship

	FATHER / HUSBAND / OTHER_____	MOTHER / WIFE / OTHER _____
NAME	_____ Last First M.I.	_____ Last First M.I.
ADDRESS	_____ Street	_____ Street
	_____ City State Zip	_____ City State Zip
TELEPHONE #	_____ Home # Work #	_____ Home # Work #
D.O.B.	_____ mo/day/yr	_____ mo/day/yr
EMPLOYER/ OCCUPATION	_____ Employer Occupation	_____ Employer Occupation

(over-see other side)

RELEASE of PATIENT'S MEDICAL INFORMATION
(18 years of age or older)

I, _____, give the following people permission to

(*Please Print Full Name*)

visit with Dr. James Troxell and his staff concerning my oral surgery records, treatment, and care:

Name	Relationship	Contact phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

●_____Date_____
Signature

***

Notice of Privacy Practices

I acknowledge that a copy of the office's Notice of Privacy Practices has been made available to me.
I have been given the opportunity to ask any questions regarding the Notice.

●_____Date_____
Signature

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you may access this information.

At our office, we keep health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The Law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another healthcare provider involved in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operation. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as an answering service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information for other disclosures which include Food and Drug Administration (FDA), Workers Compensation, Public Health, Correctional Institutions, and law/judicial enforcement.

We may use your information to contact you. For example, we may want to call and remind you about your appointments or check on your progress. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to transfer copies of our health information to another practice upon receipt of a signed release.

You have the right to see and receive a copy of your health information, with a few exceptions. Provide a written request regarding the information you want to see. If you desire a copy of your records, a reasonable fee may be assessed for the copies.

You have the right to request an amendment or change to our health information with a few exceptions. Provide your request to make changes in writing. If you wish to include a statement in your file, please submit it in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter any earlier documents, but will add the new information.

You have the right to receive a copy of this notice.

Before we make a significant change in our privacy practice, we will change this Notice, and make the new notice available upon request.

You may file a concern with the department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a concern. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at 970-482-6811.

This notice went into effect April 14, 2003.

HIPPA Confidentiality Regulation Regarding Phones/Ipads

Due to federal HIPPA confidentiality Regulations, no cell phone usage is allowed inpatient care areas. This includes phone calls, photos, videotaping and recording. Thank you for your cooperation and respect for our patients and employees' privacy.

MEDICAL-DENTAL HISTORY

What is your reason for coming to this office?

_____

Dentist _____ Orthodontist _____ Physician _____

What <u>hospital</u> operations have you had? (Type of surgery and approximate date)

_____

_____

Age _____ Height _____ Weight _____

DO <u>YOU</u> HAVE A HISTORY OF THE FOLLOWING:	**YES**	**NO**		**YES**	**NO**
Cardiovascular Disease: Heart Attack – Pacemaker - Angina - Palpitations – A-Fib- Coronary Artery Disease - Heart Surgery – Stent - Angioplasty – Valve			**Lung Disease:** Asthma – Emphysema – Bronchitis – Chronic Cough - Pneumonia - Tuberculosis		
Heart Murmur/Rheumatic Fever (age____) Do you premedicate with an antibiotic? Yes No			**Stomach Disorder:** Ulcer – Colitis		
Osteoporosis			**Joint Replacement** (knee/ hip/shoulder)		
High Blood Pressure			**Cancer:** If so, what type?_____		
Stroke/TIA			**Radiation Therapy:** (Head / Neck)		
Seizure Disorder/Epilepsy			**Steroids:** (Cortisone - Prednisone)		
Bleeding Disorder: Anemia – Bleeding Tendency - Blood Transfusion-Hemophilia-von Willebrand **Family history?**			**Recent weight gain / loss** (If yes, please circle one)		
Liver Disease: Hepatitis – Jaundice			**Venereal Disease:** Herpes - Syphilis - Gonorrhea - Chlamydia		
Kidney Disease: Kidney Stones – Infections – Dialysis			**Any disease, drug or transplant that has compromised your immune system?**		
Thyroid			**History of :** Emotional disorder		
Diabetes: Do you take Insulin? Yes No			**History of** : _____ Alcohol Dependency _____ Chemical Dependency/Recreational Drug Use		
Do you smoke? Cigarettes – Cigar – Pipe _____ per day _____ years			Have **you** or a **family member** had any problem associated with anesthesia? Malignant hyperthermia?		
Do you use chewing tobacco? Pinch/Can – Loose leaf Years _____			Do **you** have any **other disease**, **condition** or **problem** not listed above that you think the doctor should know about?		
Sleep Apnea Use CPAP or appliance			Do you wish to **speak privately** with the doctor about anything?		
Bruxism Night guard or Occlusal Splint					

WOMEN	**YES**	**NO**
Are you pregnant, or is there any chance you might be pregnant?		

SIGNATURE OF PATIENT
(Parent or Guardian if patient is a minor) **X** **DATE**

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James B. Troxell, DDS, MS *Oral and Maxillofacial Surgery*

MEDICINE QUESTIONAIRE

OFFICE INSTRUCTIONS	PRESCRIPTION MEDICATIONS	DOSAGE	TIME OF DAY

HAVE YOU TAKEN ANY OF THE FOLLOWING BONE DENSITY MEDICINES?	YES	NO				
Bisphosphonate Medications such as: Reclast, Zoledronate, Zometa, Aredia, Fosamax, Boniva, Actonel, Skelid, Bonefos, Loron, Ostac, Didronel Denosumab: (Prolia, Xgeva)			If yes, which ones: List start date		If you have stopped taking the bisphosphonate medication, please list the date you stopped:	

FOR WOMEN:	YES	NO
Do you take oral contraceptives (birth control or "the pill")		

OVER THE COUNTER MEDICATIONS, VITAMINS, DIET OR HERBAL SUPPLEMENTS

	YES	NO
Do you use marijuana? (medical / recreational)		

SIGNATURE OF PATIENT (Parent or Guardian if patient is a minor)

X_____ **Date**

ALLERGY QUESTIONAIRE

ALLERGIES

Do you have an allergy to any of the following?

Please check Yes or No

	YES	NO
Penicillin or Amoxicillin		
Sulfa or Sulfites		
Sedatives		
Aspirin		
Ibuprofen		
Codeine		
Soy		
Eggs		
Latex		

ALLERGIES

Please list additional allergies:

□ I HAVE NO KNOWN MEDICATION ALLERGIES

SIGNATURE OF PATIENT (Parent or Guardian if patient is a minor)

X _____**Date**_____

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FINANCIAL

Payment options:

- MasterCard
- Visa
- Discover
- American Express
- Check
- Cash
- Health Savings Accou
- Benefit card

Payment plans: (0% interest for 6 or 12 months)

- CareCredit (carecredit.com)
- Wells Fargo Health Advantage (WellsFargoHealthAdvantage.com/apply)

Medicare and Medicaid

- We cannot bill Medicare and Medicaid.

Insurance:

- We will file your insurance claims. Your insurance carrier will send benefit payments to you.

DENTAL INSURANCE
(Please provide card so that we may make a copy)

Insurance Name**:** _____

Address: _____

City State Zip: _____

Group #: _____

Employee/
Subscriber Name**:** _____

SS # or ID # _____

Date of Birth _____

Employer: _____

RELEASE OF INFORMATION**: I authorize the release of any dental/medical information necessary to process this claim.**

Date:_____ Signature:_____

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Date_____ Signature:_____