RED HILLS ORAL & FACIAL SURGERY

Russell Walther, DDS, MD
Oral and Maxillofacial Surgeon

WELCOME

Thank you for selecting Red Hills Oral & Facial Surgery! We strive to provide you with the best possible oral & facial surgery care. To help us meet your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We are happy to help.

PATIENT INFORMATION *(Confidential)*

Legal Name ______________________ Today's Date ______________

Soc. Sec. # ______________ Date of Birth ______________ Age ________ ☐ Male ☐ Female

Address ____

City ______________________ State ______________ Zip ______________

Home Phone (   ) ______________ Work Phone (   ) ______________ Cell (   ) ______________

Preferred Email *(For financial, insurance, and appointment information)* ______________

Full Time Student ☐ Yes ☐ No School Name ______________________

Employer ______________________ Occupation ______________________

Physician ______________________ Dentist ______________________

Previous family members treated here? ______________________

Whom may we thank for referring you to us? ______________________

GUARANTOR *(Financial responsibility and appointment scheduling)*

Name ______________________________________ ☐ Male ☐ Female

Relationship ______________ Date of Birth ______________ Soc. Sec. # ______________

Address ____

City ______________________ State ______________ Zip ______________

Employer ____

Home Phone (   ) ______________ Work Phone (   ) ______________ Cell (   ) ______________

EMERGENCY CONTACT INFORMATION

Name ______________________________ Relationship ______________

Home Phone (   ) ______________ Work Phone (   ) ______________ Cell (   ) ______________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO:

Name ______________________________ Relationship ______________

Name ______________________________ Relationship ______________

Name ______________________________ Relationship ______________

PRIMARY DENTAL INSURANCE

Insurance Company ______________________

Group # ______________________

Unique ID# ______________________

Insurance Co. Phone (   ) ______________________

Name of Policyholder ______________________

Relationship to Patient ______________________ ☐ M ☐ F

Policyholder's Date of Birth ______________________

Soc. Sec # ______________________

Employer ______________________

PRIMARY MEDICAL INSURANCE

Insurance Company ______________________

Group # ______________________

Unique ID# ______________________

Insurance Co. Phone (   ) ______________________

Name of Policyholder ______________________

Relationship to Patient ______________________ ☐ M ☐ F

Policyholder's Date of Birth ______________________

Soc. Sec # ______________________

Employer ______________________

SECONDARY DENTAL INSURANCE

Insurance Company ______________________

Group # ______________________

Unique ID# ______________________

Insurance Co. Phone (   ) ______________________

Name of Policyholder ______________________

Relationship to Patient ______________________ ☐ M ☐ F

Policyholder's Date of Birth ______________________

Soc. Sec # ______________________

Employer ______________________

SECONDARY MEDICAL INSURANCE

Insurance Company ______________________

Group # ______________________

Unique ID# ______________________

Insurance Co. Phone (   ) ______________________

Name of Policyholder ______________________

Relationship to Patient ______________________ ☐ M ☐ F

Policyholder's Date of Birth ______________________

Soc. Sec # ______________________

Employer ______________________

AUTHORIZATION

I authorize Red Hills Oral and Facial Surgery to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child, to third party payers and/or other health practitioners, to the extent permitted by law.

I understand my insurance carrier may pay less than the actual bill for services or the estimated insurance payment. I agree to be responsible for payment of all services rendered on my or my dependent's behalf within 60 days of treatment, regardless if insurance payment has been received.

Signature of Patient (parent or guardian, if minor): ______________________ Date: __________

Signature of Responsible party: ______________________ Date: __________

Please remember to bring insurance cards and driver's license to appointment.

If instructed, please bring extra items (XRAYs, other records) to appointment.

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HEALTH HISTORY

PATIENT INFORMATION

Legal Name ____________________ Today's Date ____________

Date of Birth __________ Age __________ ☐ Male ☐ Female Height __________ Weight __________

Reason for today's visit ____________________

Are you in good health? ☐ Yes ☐ No Have there been any changes to your general health in the past year? ☐ Yes ☐ No

Primary Care Physician ____________________ Cardiologist (*if applicable*) ____________________

List all conditions and illness for which you are being treated

1 ____________________
2 ____________________
3 ____________________
4 ____________________
5 ____________________
6 ____________________
7 ____________________

List any surgeries or hospitalizations with dates

1 ____________________
2 ____________________
3 ____________________
4 ____________________
5 ____________________
6 ____________________
7 ____________________

Do you have a joint replacement? ☐ Yes ☐ No If yes, where? ____________________

Have you had a heart valve replacement or a vascular graft? ☐ Yes ☐ No

Are you taking or have you taken bisphosphonates (for osteoporosis or chemotherapy for multiple myeloma, etc.)? ☐ Yes ☐ No

DO YOU HAVE OR HAVE YOU EVER HAD

Yes	No		Yes	No		Yes	No	
☐	☐	Congenital heart disease	☐	☐	Chest pain	☐	☐	Stomach ulcers or colitis
☐	☐	Heart attack	☐	☐	Shortness of breath	☐	☐	Diabetes
☐	☐	Chest pain	☐	☐	Stroke	☐	☐	Thyroid problems
☐	☐	High or low blood pressure	☐	☐	Seizure	☐	☐	Arthritis or joint disease
☐	☐	Irregular heart beat or murmur	☐	☐	Glaucoma or eye disease	☐	☐	Significant weight loss or gain
☐	☐	Pacemaker	☐	☐	Contact lenses	☐	☐	Osteoporosis or osteopenia
☐	☐	Heart Surgery	☐	☐	Kidney failure or kidney disease	☐	☐	Pain and clicking of the jaws
☐	☐	Asthma	☐	☐	Dialysis	☐	☐	Frequent mouth sores
☐	☐	Chronic cough	☐	☐	Liver disease (jaundice, hepatitis)	☐	☐	Cancer
☐	☐	Emphysema, bronchitis, or COPD	☐	☐	Bleeding problems	☐	☐	Radiation therapy
☐	☐	Snoring	☐	☐	Anemia	☐	☐	Chemotherapy
☐	☐	Sleep apnea	☐	☐	Blood transfusion	☐	☐	Organ Transplant

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

If yes, please explain: ____________________

MEDICATIONS

Yes	No	
☐	☐	Blood Thinners
☐	☐	Antibiotics
☐	☐	Pain Medication
☐	☐	Steroids

Please list all current medications:

1 ______________________
2 ______________________
3 ______________________
4 ______________________
5 ______________________
6 ______________________
7 ______________________
8 ______________________
9 ______________________
10 ______________________

ALLERGIES

Yes	No	
☐	☐	Antibiotics
☐	☐	Sedatives, barbiturates
☐	☐	Codeine or pain killers
☐	☐	Local anesthesia
☐	☐	Latex
☐	☐	Food products
☐	☐	Adhesive

Please list all allergies:

1 ______________________
2 ______________________
3 ______________________
4 ______________________
5 ______________________
6 ______________________
7 ______________________

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

Is this visit accident related?

Yes	No	
☐	☐	Automobile accident
☐	☐	Work related accident
☐	☐	Other accident

Date of accident: ______________

FEMALES ONLY

Yes	No	
☐	☐	**Are you possibly pregnant**?

Delivery date: ________________

Yes	No	
☐	☐	**Are you taking birth control**?

Please Note: Antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

SOCIAL AND FAMILY HISTORY

Have you ever sought professional care or been hospitalized for?

Yes	No	
☐	☐	Drug Abuse
☐	☐	Emotional disorders
☐	☐	Alcoholism

Do you use?

Yes	No		
☐	☐	Alcohol	How often ___________
☐	☐	Marijuana	How often ___________
☐	☐	Recreational drugs	How often ___________

☐ ☐ Have you smoked or chewed tobacco? If yes, for how long?______________________________

Do you have a family history of any of the following? If yes, indicate which relative.

Yes	No			Yes	No		
☐	☐	Diabetes	Relative ____________	☐	☐	Cancer	Relative ____________
☐	☐	Heart Disease	Relative ____________	☐	☐	Bleeding problems	Relative ____________
☐	☐	Fever with anesthesia	Relative ____________	☐	☐	Lung disease	Relative ____________

AUTHORIZATION

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my surgeon or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I authorize my surgeon and his staff to complete an oral and maxillofacial exam for the purposes of diagnosis and treatment planning. Furthermore, I authorize the taking of all radiographic imaging as required for my treatment.

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

Signature of Patient (parent or guardian, if minor): ______________________________ Date: ______________

Please remember to bring insurance cards and driver's license to appointment.

If instructed, please bring extra items (XRAYs, other records) to appointment.

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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 wisdom teeth removal.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization 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 aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

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

We may contact you or your designees at the numbers you provide on your patient information form to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of an interest to you. We may leave messages on answering machines or voice mails regarding your appointment, surgical instructions, insurance or payment information.

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 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 account of disclosures of protected health information.

- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.

- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

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 August 1, 2016, 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 a formal, written complaint with us at our address below, or with the Department of Health & Human Services, Office of Civil Rights, about violation 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:

Safety & Privacy Officer

Red Hills Oral and Facial Surgery
Tallahassee, FL 32308
850.523.3000

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 SW
Washington, DC 20201

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Red Hills Oral and Facial Surgery's Notice of Privacy Practices, which has an effective date of 8/1/2016, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I may be provided a copy upon request of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

____ ______________________

Signature of Patient or Patient's Representative Date

____

Print Name

____

Relationship to Patient (If not signed by the Patient)