ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NEA OMS | NORTHEAST ARKANSAS CENTER FOR ORAL AND MAXILLOFACIAL SURGERY

IF YOU WISH TO OBTAIN A COPY OF OUR PRIVACY PRACTICES, PLEASE INFORM THE STAFF UPON RETURNING THIS FORM.

I have received a copy of Northeast Arkansas Center for Oral and Maxillofacial Surgery, Notice of Privacy Practices which describes how my health information is used and shared. I understand that Northeast Arkansas Center for Oral and Maxillofacial Surgery, has the right to change this notice at any time. I may obtain a current copy by contacting the Facility Privacy Officer, or by visiting the Facility website at www.neaoralsurgery.com.

In the event of a medical emergency, NEA Center for Oral and Maxillofacial Surgery does not accept advance directives for non- resuscitation. **Advanced directives** will be included with transfer to a higher level of care if provided.

Questions concerning this policy can be directed to the clinic manager; Medicare.gov or Arkansas Code Title 20-6-103.

My signature below acknowledges a copy was offered/received. **(Not necessarily read).**

_____

Signature of patient, parent, or guardian **Date**

_____

Printed name of patient, parent, guardian/relationship

_____

Personal Representative and Title (e.g. Guardian, Executor of Estate, Power of Attorney)

FOR FACILTITY USE ONLY:

If the patient or patient's representative is unwilling or unable to sign this Acknowledgement, state the reason and describe the steps taken to obtain the signature.

_____

Facility Representative Signature **Date**

_____

Printed name of Facility Representative

HEALTH HISTORY FORM

NEA OMS | NORTHEAST ARKANSAS CENTER FOR ORAL AND MAXILLOFACIAL SURGERY

FEMALE PATIENTS

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

MEDICATIONS

Are you using any of the following:

	YES	NO		YES	NO
Antibiotics?	◯	◯	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	◯	◯
Anticoagulants (blood thinners)?	◯	◯	Insulin or oral anti- diabetic drugs?	◯	◯
Heart drugs?	◯	◯	High blood pressure medications?	◯	◯
Steroids (cortisone, prednisone, etc.), antianxiety agents, sedative hypnotics and antidepressants?	◯	◯	Bisphosphonates, antiangeogenic, and/or antiresorptive medications for opteoporosis, multiple myeloma or other caners? If yes, list drugs used and time of use.	◯	◯
Prescription pain medication?	◯	◯			

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal, or holistic remedies, vitamins or minerals:

_____

ALLERGIES

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

Latex?	YES ◯ NO ◯	Codeine or other pain killers?	YES ◯ NO ◯
Food products?	YES ◯ NO ◯	Aspirin, Motrin, Aleve, or Ibuprofen?	YES ◯ NO ◯
Sedatives, barbiturates?	YES ◯ NO ◯	Penicillin or other antibiotics?	YES ◯ NO ◯

Have you or an immediate family member had any problems associated with local anesthesia, general anesthesia and/or intravenous sedation?

◯ Yes ◯ No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies, not listed above: _____

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 ◯	Alcohol?	YES ◯ NO ◯ HOW OFTEN? _____
Emotional disorder?	YES ◯ NO ◯	Marijuana?	YES ◯ NO ◯ HOW OFTEN? _____
Alcoholism?	YES ◯ NO ◯	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 If yes, please explain _____

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, or guardian **Date**

_____

Printed name of patient, parent, guardian/relationship

HEALTH HISTORY

NEA OMS | NORTHEAST ARKANSAS CENTER FOR ORAL AND MAXILLOFACIAL SURGERY

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 10 each question honestly and completely. Please circle your responses.

Please describe your current health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Please describe any 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? _____ Physician's Name: _____

Have you ever been hopsitalized or had a serious illness? ◯ Yes ◯ No

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

PATIENT MEDICAL HISTORY

Do you have or have you ever had:	YES	NO
Congenital heart disease, cardiovascular disease (heart	◯	◯
attack, heart murmur, coronary artery disease, chest pain,	◯	◯
high/low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	◯	◯
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	◯	◯
Kidney disease or kidney failure, requiring dialysis?	◯	◯
Thyroid disease?	◯	◯
Stomach ulcers or colitis?	◯	◯
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	◯	◯
Frequent or recurring mouth sores?	◯	◯
Radiation to the head or neck for cancer treatment ?	◯	◯
Any disease, chemotherapy or transplant operation?	◯	◯

If so, where? _____

Date of last treatment? _____/_____/_____

	YES	NO
Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	◯	◯
Glaucoma?	◯	◯
Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	◯	◯
Liver disease (Jaundice, hepatitis A, B, or C)	◯	◯
Diabetes?	◯	◯
Arthritis?	◯	◯
Significant weight loss or gain?	◯	◯
Seizures, convulsions, epilepsy, fainting or dizziness?	◯	◯
Sinus or nasal problems?	◯	◯
Osteoporosis or osteopenia?	◯	◯
Do you have any other disease, condition or problem not listed above that you think the doctor should know about?	◯	◯

If yes, please explain: _____

_____

FAMILY MEDICAL HISTORY

Diabetes? ◯ Yes ◯ No ◯ Relationship

Heart Disease? ◯ Yes ◯ No ◯ Relationship

Tumors? ◯ Yes ◯ No ◯ Relationship

Cancer? ◯ Yes ◯ No ◯ Relationship

Bleeding problems? ◯ Yes ◯ No ◯ Relationship

Lung disease? ◯ Yes ◯ No ◯ Relationship

NEW PATIENT OVER 18

NORTHEAST ARKANSAS CENTER FOR ORAL AND MAXILLOFACIAL SURGERY

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

Gender: ◯ Male ◯ Female SSN _____

Home Address _____

City _____ State _____ Zip _____

Billing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Would you like to be confirmed via text or email ◯ Yes ◯ No Best number to send texts to: _____

Email: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Relationship to Patient _____ Phone _____

MEDICAL INSURANCE

Insurance Company Name _____

Claims Address _____

Phone _____ Group Number _____ ID Number _____

Insured's Name _____ Relation to Patient _____

Insured's DOB _____ SSN _____ Employer _____

DENTAL INSURANCE

Insurance Company Name _____

Claims Address _____

Phone _____ Group Number _____ ID Number _____

Insured's Name _____ Relation to Patient _____

Insured's DOB _____ SSN _____ Employer _____

I understand that even though I have some insurance coverage, I am responsible for payment of services. I authorize release of information to my insurance company and referring dentist/physician. I hereby authorize my insurance company to release payment directly to Northeast Arkansas Center for Oral and Maxillofacial Surgery. I have completed this form fully and certify that I am the patient and/or dully authorized agent of the patient authorized to furnish the information request. I hereby acknowledge that I have received a copy of these practices, notice of privacy practices. I have been given the opportunity to ask any questions I may have regarding this notice.

_____

Signature **Date**

NEW PATIENT UNDER 18

NORTHEAST ARKANSAS CENTER FOR ORAL AND MAXILLOFACIAL SURGERY

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

Gender: ◯ Male ◯ Female SSN _____

*PARENT'S/LEGAL GUARDIAN INFORMATION

Are you the patient's legal guardian? ◯ Yes ◯ No

Father's/Legal Guardian's Name _____ Date of Birth ____/____/____

SSN _____ Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Mother's/Legal Guardian's Name _____ Date of Birth ____/____/____

SSN _____ Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Billing Address _____

City _____ State _____ Zip _____

Would you like to be confirmed via text or email ◯ Yes ◯ No Best number to send texts to: _____

Email: _____

MEDICAL INSURANCE

Insurance Company Name _____

Claims Address _____

Phone _____ Group Number _____ ID Number _____

Insured's Name _____ Relation to Patient _____

Insured's DOB _____ SSN _____ Employer _____

DENTAL INSURANCE

Insurance Company Name _____

Claims Address _____

Phone _____ Group Number _____ ID Number _____

Insured's Name _____ Relation to Patient _____

Insured's DOB _____ SSN _____ Employer _____

I understand that even though I have some insurance coverage, I am responsible for payment of services. I authorize release of information to my insurance company and referring dentist/physician. I hereby authorize my insurance company to release payment directly to Northeast Arkansas Center for Oral and Maxillofacial Surgery. I have completed this form fully and certify that I am the patient and/or dully authorized agent of the patient authorized to furnish the information request. I hereby acknowledge that I have received a copy of these practices, notice of privacy practices. I have been given the opportunity to ask any questions I may have regarding this notice.

_____

Signature **Date**

PATIENT DISCLOSURE INSTRUCTIONS

NEA OMS | NORTHEAST ARKANSAS CENTER FOR ORAL AND MAXILLOFACIAL SURGERY

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses anddisclosures oftheir protected health information (PHI). The individual is also provided the right to request confidential communications dr that a communication of PHI be made by alternative means, such as sending correspondence to the individual office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

- ◯ Home Telephone _____
  - ◯ Ok to leave message with detailed information
  - ◯ Leave message with call-back number only
- ◯ Work Telephone: _____
- ◯ Written Communication
  - ◯ Ok to mail my home address
  - ◯ OK to mail my work/office address
  - ◯ Ok to-fax to number indicated
  - ◯ Ok to text to cell phone
- ◯ Other (Fax/Cell, etc.): _____

I allow you to give my clinical information to or.answer questions from{check all that applies):

- ◯ Spouse
- ◯ Parent
- ◯ Child
- ◯ Other (specify): _____
- ◯ None

_____

Signature of patient (Parent, or Guardian if patient is under 18) **Date**

_____

Printed name of patient (Parent, or Guardian if patient is under 18)

PATIENT NO-SHOW, LATE SHOW, AND CANCELLATION POLICY

NEA OMS | NORTHEAST ARKANSAS CENTER FOR ORAL AND MAXILLOFACIAL SURGERY

Dear Patient:

When we make your appointment, we are reserving a time slot for you with the doctor. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible for us to give your reserved slot to another patient.

We make every effort to be on time for all our appointments. Unfortunately, when even one patient arrives late, it can throw off the entire schedule for that session. In addition, rushing or "squeezing in" an appointment shortchanges the patient and contributes to decreased quality of care (and increases medical errors). In light of this, **patients arriving more than 5 minutes after their appointment time will be asked to reschedule.** We apologize for any inconvenience this might cause.

Repeated cancellations or missed appointments will result in loss of all future appointment privileges.

By implementing this policy, we believe we honor patients who schedule/keep appointments, while also trying to accommodate everyone inn a fair and efficient manner. Thank you for your cooperation.

Printed name of patient, parent, or guardian **Date**

Signature of patient, parent, guardian/relationship