PATIENT MEDICAL HISTORY

Name_____ Home Phone (___)_____
Last First Middle Work Phone (___)_____
Date of Birth____/____/_____ SS#_____ Sex: M F Height_____Weight_____
Closest Relative_____Relationship to Patient_____Phone_____
Family Physician_____Address_____Phone_____
Date of last physical exam_____
Who is your general dentist?_____Orthodontist?_____
Who referred you to our office?_____

Please circle if you now have or previously have had any of the following:

Heart Disease	Low Blood Pressure	Psychiatric Treatment	Arthritis
Heart Attack	Bleeding Disorder	Immune System Problems	Anemia
Chest Pain (Angina)	Liver Disease	Fainting	Asthma
Heart Murmur	Hepatitis	Convulsions	Glaucoma
Congenital Heart Defect	Jaundice	Seizures	Thyroid Disease
Rheumatic Fever	Stomach Ulcer	Allergies	Kidney Disease
Rheumatic Heart Disease	Tuberculosis	Diabetes	Cancer
High Blood Pressure	Shortness of Breath	Sinusitis	Artificial Joints

History of TMJ popping pain (Right_____Left_____) Problems with Healing_____

Comments on above:_____

Please circle if you are allergic or have had a reaction to any of the following:

Local Anesthetics	Penicillin or other antibiotics	Iodine	Latex
Barbiturates	Aspirin	Other_____	
Codeine or other narcotics	Sulfa Drugs	Foods_____	

Please list your current medications including non-prescription medications:_____

Have you had any serious illness, operation, or been hospitalized in the past 5 years?_____
If so, explain briefly._____
Are you currently under the care o a doctor for any condition? (List)_____
Have you ever used or do you use any street drugs? (List)_____
Have you ever smoked, dipped or chewed tobacco?_____
Do you drink alcoholic beverages?_____

Female – Are you pregnant or nursing?_____Due date_____Obstetrician_____
Are you taking birth control pills?_____
Have you had any serious trouble associated with previous dental treatment?_____
Do you have any disease, condition, or problem no listed above that you think I should know about?_____
If so, explain briefly_____
Do you have any medical issues that you wish to discuss privately with your doctor?_____
What kind of problem are you having today? _____

The signature below represents my agreement to the following: I have answered all of the questions above truthfully and have revealed my complete medical history to the Doctors and staff of Oral & Facial Surgery of the Shoals, L.L.C. I will not hold my doctor, or any other member of his staff responsible for my error or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient of Legal Guardian Date

Reviewed by:_____ Physician:_____ Date Reviewed:_____

HIPAA Privacy Practices Notice

Oral & Facial Surgery of the Shoals, L.L.C.
398 Ashe Boulevard
Sheffield, Alabama 35660
(256) 383-1499

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you. It is standard practice for our office to send a letter to your dentist an/or medical doctor stating the treatment we have provided for you. In cases where pathology is involved, we may send a copy of the report with that letter so that he/she will be aware of your diagnosis.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. It is also very common for insurance companies to request preoperative x-rays for dental surgeries and in some cases, request medical records prior to payment. We will disclose the minimum necessary information to meet their requirements for payment. We also may turn over personal demographic information to our attorney to collect on unpaid accounts when necessary.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's or medical doctor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose our protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We will call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may leave messages on answering machines when necessary and send out recall letters in some situations.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect; Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164,500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing except to the extent that your doctor or the doctor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect o your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your doctor is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before June 3, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (256) 383-1499.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ SIGNATURE:_____ Date:_____