PATIENT INFORMATION SHEET

NELSON & ROLLERT Associates in Oral & Maxillofacial Surgery, Prof. L.L.C.

Today's Date ____________________

Title: (Mr., Mrs., Ms., Dr.) First Name: ______________________ M.I.: _______ Last Name: ____________________________

Sex: ☐Male ☐Female Date of Birth: ____________ Age: ______ Social Security No.: ______________________

Street: ____

City: ____ State: ________ Zip: _______________

Home Tel.: (____) ______________________________ Bus. Tel.: (____) ____________________________ Ext.: ______

Cell Phone: (____) ______________________________ Dentist: ___________________________ Tel.: ____________

Physician: ______________________ Tel.: ____________ Orthodontist: ________________________ Tel.: ____________

Emergency Contact: ____ Tel.: (____) ____________________

Reason for Being Referred to Our Office: _______________________________ Referred By: _____________________

Family Members Who Have Been Patients: ____

Student: ☐Full Time ☐Part Time ☐Not School Name/Address: ____

☐Married ☐Divorced ☐Legally Separated ☐Widow ☐Single

Employed: ☐Full Time ☐Part Time ☐Retired ☐Not

DENTAL INSURANCE COMPANY

Name: ____

Address: ____

____

Phone: (____) ___________________________________

Group No.: _____________ Group Name: ______________

Insurance ID: ____________________________________

INSURED PARTY:

Name: ____

Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Date of Birth: ____________________________________

Street: ____

City, State, Zip: __________________________________

Phone: (____) ____________________________________

Social Security No.: _______________________________

Employer: ____

SECONDARY DENTAL INSURANCE COMPANY:

Name: ____

Address: ____

____

Phone: (____) ___________________________________

Group No.: _____________ Group Name: ______________

Insurance ID: ____________________________________

RESPONSIBLE PARTY:

Name ____

Address: ____

____

Tel.: (____) _____________________________________

Work Tel.: (____) _________________________________

Cell Tel.: (____) __________________________________

Employer ____

FEES AND PAYMENTS:

I hereby accept responsibility for payment for any service(s) provided that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. **It is important to call your dental insurance so you understand your coverage.**

I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to Nelson & Rollert Oral and Maxillofacial Surgery.

We are unable to bill separate parties. By signing this form you are financially responsible for any balance not paid for by your insurance company.

Responsible Party Signature: ____

HEALTH HISTORY

NELSON & ROLLERT Associates in Oral & Maxillofacial Surgery, Prof. L.L.C.

PLEASE PRINT Answer all questions by checking Yes (Y) or No (N). ALL RESPONSES ARE KEPT CONFIDENTIAL. *Today's Date* ____/____/____

1. Are you in good health? .... Y N
2. Has there been any change in your general health in the past year? .... Y N
3. Date of last physical exam? ______/______/______
4. Are you now under a physician's care for a particular problem? .... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: .... Y N

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   ____
6. Height_____ Weight_____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Infective Endocarditis? .... Y N
   - B. Congenital Heart Disease? .... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Mitral Valve Prolapse, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? .... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? .... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y N
   - H. Kidney Disease? .... Y N
   - I. Diabetes? .... Y N
   - J. Thyroid Disease (Goiter)? .... Y N
   - K. Arthritis? .... Y N
   - L. Stomach Ulcers or Colitis? .... Y N
   - M. Glaucoma? .... Y N
   - N. Implants placed anywhere in your body (Heart, Pacemaker, Hip, Knee)? .... Y N
   - O. Radiation (X-ray) treatment for Cancer? .... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .... Y N
   - Q. Sinus or Nasal problems? .... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
   - S. HIV, AIDS or ARC? .... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING?**
   - A. Antibiotics? .... Y N
   - B. Anticoagulants (Blood Thinners)? .... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? .... Y N
   - D. High Blood Pressure medications? .... Y N
   - E. Steroids (Cortisone, etc.)? .... Y N
   - F. Tranquilizers? .... Y N
   - G. Insulin or Oral Anti-Diabetic drug? .... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other Heart drug? .... Y N
   - I. Are you taking or have you ever taken Bisphosphonates? (Fosamax, Actonel, Boniva, Aredia, Zometa) .... Y N
   - J. Any regular medicine, herbal or vitamin supplements? If Yes, please list? .... Y N

   ____

   ____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocaine, etc.)? .... Y N
   - B. Penicillin or other antibiotics? .... Y N
   - C. Sedatives, Barbiturates? .... Y N
   - D. Aspirin or Ibuprofen? .... Y N
   - E. Codeine or other pain killers? .... Y N
   - F. Latex or Rubber Products? .... Y N
   - G. Other allergies or reactions? Please list .... Y N

   ____

   ____
10. Do you Smoke or Chew Tobacco? .... Y N

    How much per day?__________ How many years?__________
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y N
12. Have you had any serious problems associated with any previous dental treatment? .... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? .... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
15. Do you wish to talk with the doctor privately about anything? .... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? .... Y N
    - B. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

DATE	*SIGNATURE OF PERSON COMPLETING HEALTH HISTORY*	*DOCTOR'S INITIALS*

MEDICAL UPDATE: *I have read my Health History dated ____/____/____ and confirm that it adequately states past and present conditions.*

DATE	*EXCEPTIONS OR CHANGES*	*PATIENT'S SIGNATURE*	*DOCTOR'S INITIALS*
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Nelson & Rollert

Associates in Oral & Maxillofacial Surgery, Prof. L.L.C.

Notice of Privacy Practices

This notice describes how protected medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

1. Nelson & Rollert, Associates in Oral & Maxillofacial Surgery, Prof. L.L.C. (Nelson & Rollert) is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples.
    a. For treatment – We may use and disclose your health information to a healthcare provider providing treatment to you.
    b. For payment – We may use and disclose your health information to obtain payment for services we provide you.
    c. For health care operations – We may use and disclose your health information in connection with our health care operations. Health care operations may include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
2. Nelson & Rollert is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Examples of these circumstances may be as required by law or in the case of national security.
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. Nelson & Rollert intends to engage in one or more of the following activities:
    a. Nelson & Rollert may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
    b. A group health plan, or health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
5. The individual has the following rights regarding protected health information:
    a. The right to request restrictions on certain uses and disclosures of protected health information. Nelson & Rollert is not required to agree to a requested restriction, however.
    b. The right to receive confidential communications of protected health information as applicable.

c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.

d. The right to amend protected health information, as provided in the Privacy Regulation.

e. The right to receive an accounting of disclosures of protected health information.

f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

6. Nelson & Rollert is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
7. Nelson & Rollert is required to abide by the terms of the Notice currently in effect.
8. Nelson & Rollert reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. Nelson & Rollert will provide individuals or patients with a revised Notice by written request.
10. Individuals may complain to Nelson & Rollert and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A complaint may be filed by submitting a written request to the contact person listed below.
11. I understand that Nelson & Rollert may communicate, via email, health information with other practitioners. This could include, but is not limited to, radiographs, treatment plan information and diagnoses.
12. Nelson & Rollert is authorized to release any medical or financial information regarding my treatment to the following parent / persons(s) below:

    ____

13. Nelson & Rollert's contact person for matters relating to complaints is:

    Office Manager at 303-758-6850:

This Notice is first in effect on April 14, 2003.

I hereby acknowledge that I have reviewed a copy of Nelson & Rollert's Notice of Privacy Practices.

____

Individual's Name

____

Date