DRS. SMITH & IVERS

Patient Information

Last Name_____ First Name_____ Middle Initial_____Age_____
Mr / Dr/ Mrs/ Miss/ Ms **O** Male **O** Female **O** Single **O** Married **O** Widowed **O** Divorced

MailingAddress:_____City_____zip_____
Home Phone_____ Work Phone_____Cell Phone _____
Social Security Number_____ Date of Birth_____Email_____
Employer _____Occupation _____ Empl Add:_____
If College Student: Name of School_____ City_____ State _____FT or PT
If Married Spouse Name _____ Spouse Phone _____

Emergency Contact
Name:_____Relationship_____Phone_____

Account Information

O Person responsible for account is the same as above Yes or No---- If not the same as above please fill out below.

Last Name _____ First Name _____ Middle Initial _____
MailingAddress_____City_____State_____Zip_____
Date of Birth_____ **O** Male **O** Female **O** Single **O** Married **O** Widowed **O** Divorced
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number _____ Drivers License Number _____State____
Email_____Occupation_____Employer_____
Employer Phone _____

Insurance Information

	Primary Dental	Primary Medical	Secondary Dental	Secondary Medical
Insurance Company				
Subscriber Name				
Subscriber Employer				
Relationship to patient				
Insured ID# SS Number				
Group Number				
Insurance Address				
Insurance Phone				

PLEASE COMPLETE

General Dentist _____ **Phone** _____
Referred to us by _____ **Phone** _____

Financial Statement and Agreement

I do authorize and give consent to Drs. Smith & Ivers and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient. I also give my permission to request and obtain records from any source necessary in the treatment and/or diagnosis for the above named patient.

I understand that I am responsible for all covered and non-covered services performed. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits. I am aware that in the event I or my insurance company does not pay for services rendered that I will be responsible for all collection fees and court costs. Please understand that your insurance is a contract between you and your insurance company. Insurance claims which are denied, rejected or not paid within sixty (60) days will be your personal obligation. Your assistance in seeing that this claim is paid within this time period will be appreciated.

If you do not have insurance coverage, you are responsible for all charges for services performed.

Responsible Party Signature _____ Print Name _____ Date _____

DRS. SMITH & IVERS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM DRS. SMITH & IVERS

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

AUTHORIZATION TO RELEASE APPOINTMENT/REFERRAL INFORMATION

I hereby authorize the physicians and/or staff of Drs. Smith & Ivers to release appointment, referral information, prescription information, etc. as indicated below.

_____ Information may be left on the home or work answering machine.

_____ Information may be shared with the following individuals.

_____

_____

I understand that this authorization will be maintained in my medical record. I have the right to update this authorization at any time by submitting a request in writing signed by me.

I hereby give providers of Drs. Smith & Ivers my permission to provide treatment for me as medically necessary.

_____ _____
Signature Date

_____
Witness (office personnel)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (please specify) _____

HEALTH HISTORY

Patient Name _____ Date of Birth _____ Height _____ Weight _____ Age _____

*** Are you allergic to anything _____ if yes, please list:** _____

_____

* Are you in good health?.....Yes or No If not explain _____

* Reason for seeking treatment with our office _____

* Have you been hospitalized or had a serious illness in the last three years?_____ if yes please explain _____

_____

* Family Physician _____ Physician Phone _____ Are you being treated by them now ____

Please list other doctors that are currently treating you (Name, Phone Number and Reason for treatment) _____

_____

* Are you taking or have you ever taken Biophosphonates (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) for osteoporosis, multiple myeloma or other cancers? Yes or No , if yes explain_____

** Do you currently use tobacco: ___ O Cigarettes O Pipe O Smokeless tobacco ___ amount per day ____per week

** Do you drink alcohol _____ O Beer O Liquor O Wine _____ amount per day _____ per week

**** Please list all current Medications including Rx by doctor, over the counter drugs, etc.****

_____

_____

_____

_____

_____

_____

DO YOU HAVE OR HAVE YOU HAD : (circle yes or no)

Heart disease	Yes	No	Heart attack or defects	Yes	No	Heart murmer	Yes	No
Rheumatic fever	Yes	No	Stroke	Yes	No	High blood pressure	Yes	No
Mitral Valve disorder	Yes	No	Pacemaker	Yes	No	Valve replacement	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	TB,emphysema	Yes	No
Diabetes	Yes	No	COPD	Yes	No	Kidney Disease	Yes	No
Artificial hip/knee	Yes	No	Thyroid disease	Yes	No	stomach ulcer/colitis	Yes	No
Liver Disease	Yes	No	Hepatitis	Yes	No	glaucoma	Yes	No
Radiation Tx for cancer	Yes	No	Chemotherapy	Yes	No	Osteoporosis	Yes	No
Dizziness	Yes	No	Lupus	Yes	No	Epilepsy	Yes	No
Arthritis	Yes	No	Seizures	Yes	No	Fainting spells	Yes	No
Sickle Cell disease	Yes	No	Nervous System disord	Yes	No	Psychiatric care	Yes	No
depression/anxiety	Yes	No	Cancer/Tumors	Yes	No	blood transfusion	Yes	No
bleeding problems	Yes	No	TMJ Pop/lock	Yes	No	hard to open/close mouth	Yes	No
Sleeping disorders	Yes	No	difficulty swallowing	Yes	No	difficulty chewing	Yes	No
herpes	Yes	No	VD(syphilis gonorrhea)	Yes	No	HIV	Yes	No

Other _____

Women: Are you pregnant, or is there any chance you might be pregnant?___ Are you nursing? ____ Taking contraceptives? _____

*antibiotics and some other medications decrease the effectiveness of oral contraceptives (birth control) so use another form of birth control while on those medications

All Patients:

~~ Have you had any serious problems associated with any previous dental treatments?_____

~~Have you or an immediate family member had any problem associated with IV anesthesia? _____

~~ Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ___

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or minor child, the patient) health I will not hold my dentist or any member of his/her dental team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my dentist of any changes in the above medical status.

Patient or Responsible Party Signature: X_____ Date: _____ Physician's Initials ___

RECALL REVIEW: Update's

1. Patient/Responsible Party Signature _____Date:_____ Physician's initials ____

Smith and Ivers, LLC
Oral and Maxillofacial Surgery

Pharmacy Information Form:

Pharmacy Name:_____

Pharmacy Address: _____

_____

Pharmacy Phone Number#:_____

By signing this document, you agree for our office to attempt to fill your prescriptions via EPrescription to the pharmacy above. If for some reason the prescription you go to a different pharmacy, it could be difficult to change the prescription to another location. Please go to this Location and get the Prescription filled by the pharmacy provided above.

Patient Name _____

Patient Signature _____

Date _____

RELEASE AND WAIVER OF LIABILITY
OF
MEDICARE PATIENTS

(Please complete if aged 65 or older.)

Patient Name **Date**

DRS. SMITH & IVERS are NOT Medicare providers. DRS. SMITH & IVERS do not file Medicare claims. Medicare does not generally cover any routine dental services. Additionally, Medicare will not pay for services that are determined to be "reasonable and necessary" under Section 1862 (a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare program standards, Medicare may deny payment for that service. Medicare may also deny any services outside of this office such as laboratory fees and prescriptions.

Patient Release:

I have read this Release and Waiver of Liability Form and I understand that DRS. SMITH & IVERS are NOT Medicare providers. I agree to be personally and fully responsible for the payment of all such non-covered services.

Medicare Beneficiary Signature **Date**

Witness Signature **Date**

Drs. Smith & Ivers

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect 01/01/17 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care.
We may disclose your health information to your family and friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to

- Prevent or control disease, injury, or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceeding. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure or psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative location, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: _____

Telephone: 901-685-8090 Fax: 901-684-1662

Address: 766 S. White Station, Suite 1 Memphis, TN 38117

Email: office@memphisoralsurgery.com