HILLSBORO ORAL AND MAXILLOFACIAL SURGERY, LLC. · DYLAN SPENDAL, DMD
5025 NE Elam Young Parkway · Suite 100 · Hillsboro, OR 97124 · Office: 971.371.3120 · Fax: 971.371.3121

Patient Information Sheet

PATIENT NAME: (Mr. ☐ Mrs. ☐ Ms. ☐) Today's Date:___/___/_____

First Name: _____ Middle Initial: _____ Last Name: _____ **Suffix:** _____

Date of Birth:___/___/_____ Age: _____ Social Security No.: _____ Sex: ☐ Male ☐ Female

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Telephone: (___) _____ Cell Phone: (___) _____ Work Phone: (___) _____ Ext: _____

E-mail Address: _____

Dentist: _____ _____ Physician: _____ _____
First Name Last Name First Name Last Name

Referred by: _____ _____ Referral Phone No.: (___) _____
First Name Last Name

Parent Name (if patient is a minor or dependent):_____ Social Security No.: _____

Parent Address: _____ Parent Phone #: (___) _____

Student: ☐ Full Time ☐ Part Time ☐ Not School Name: _____

☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow

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

Employer Name: _____ Telephone: (___) _____

Employer Address: _____

Emergency Contact Name: _____ _____ Telephone: (___) _____
First Name Last Name

Patient Relationship to Emergency Contact: _____

****

Dental Insurance Co._____ ID No.:_____

Insurance Co. Address: _____ _____ ____ _____ Phone #: (___) _____
Street City State Zip

Group Name: _____ Group No.: _____

Subscriber Name: _____ _____ Social Security No.: _____
First Name Last Name

Address (if different from patient): _____

Phone No. (if different from patient): (___) _____ Date of Birth:___/___/_____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

****

Medical Insurance Co. _____ ID No.: _____

Insurance Co. Address: _____ _____ ____ _____ Phone #: (___) _____
Street City State Zip

Group Name: _____ Group No.: _____

Subscriber Name: _____ _____ Social Security No.: _____
First Name Last Name

Address (if different from patient): _____

Phone No. (if different from patient): (___) _____ Date of Birth:___/___/_____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

****

Do you have Secondary Insurance? ☐ Yes ☐ No ☐ Medical ☐ Dental

Secondary Insurance Company Name: _____

Group Name: _____ Group No.: _____

Subscriber Name: _____

This signature on file is authorization for release of information necessary to process my claim. I hereby authorize payment directly to the doctor named of the benefits otherwise payable to me.

Signature: _____ Date: _____

HILLSBORO ORAL AND MAXILLOFACIAL SURGERY

Health History Form

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

Please describe your current health: Excellent Good Fair Poor

Please describe the 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? _____ Date of last physical exam ____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why? _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No
If so, where? _____, and when was the date of your last treatment? _____

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

If yes, please explain: _____

FEMALE PATIENTS

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

Health History Form

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

MEDICATIONS

Are you using any of the following:

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

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 allergic to or have you 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 problem 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:			**Do you use:**			
Drug abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	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

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, guardian Date

_____ _____
Printed name of patient, parent, guardian/Relationship Doctor's Signature

☐ Approved for Surgery ☐ Requires medical or medication consultation

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Dental X-ray Consent Form

Dental X-rays allow the dentist to diagnose and treat conditions that cannot be detected during clinical examination.

Dental X-rays are a part of a comprehensive oral examination. However, your dental insurance may not cover the fee for X-rays.

Please Select One Option:

_____ New dental X-rays may be taken. I understand that they may or may not be covered by my dental insurance. I understand that I am responsible for all fees if my insurance company does not pay for the X-rays.

_____ I have requested that no dental X-rays be taken today. I understand that some dental pathology cannot be diagnosed without the use of dental X-rays. I hereby release Hillsboro Oral and Maxillofacial Surgery from responsibility for any oral conditions undiagnosed as a result of my request that no dental X-rays be taken.

_____

Patient Name

_____

Patient Signature or Guardian if Patient is a Minor

_____

Date

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FINANCIAL POLICY

Welcome! Thank you for selecting us as your oral surgery team. We want you to feel welcome and as comfortable as possible throughout your visit. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:

Patients are expected to pay for their services at the time they are rendered unless prior arrangements have been made. There is a fee for consultations, X-rays, and surgical services provided. A deposit is required the day of the surgical procedure. This amount will be determined after your consultation. Payments may be made using, cash, check, Visa, MasterCard, and/or Discover. We will mail monthly statements to all patients with an outstanding balance. Finance charges will apply after 90 days at 18% per annum.

There may be a fee for any additional procedure(s) not included in the original treatment plan.

We do not accept Medicare or Medicaid. We may provide services to you with the understanding that insurance will not be billed for services rendered.

If a pathology specimen is sent to the lab, you will receive a separate bill from the lab for their services. **Please note: You will receive a separate bill from the lab for these services.**

INSURANCE INFORMATION:

As a courtesy, we will submit claims to your insurance company. To maximize your insurance benefits we will need your insurance card and/or insurance policy.

If your insurance has not paid within 90 days of services rendered, we will look to you for full payment. After 90 days, the patient is responsible to pursue payment from the insurance company.

I authorize my insurance carrier(s) to issue payment to Hillsboro Oral and Maxillofacial Surgery or Dylan Spendal, D.M.D.

Please indicate your understanding and acceptance of these financial policies by signing below.

_____

Patient Name (please print)

_____ _____

Patient Signature or Guardian if Patient is a Minor Date

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Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of use of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of use of your information for health care operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Ask someone who has medical power of attorney or your legal guardian, to exercise your rights and make choices about your health information.
- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment of health care operations; and the PHI pertains full-we must comply with this request;
- Request you be allowed to inspect your health record and billing record – you may exercise this right by delivering the request in writing to our office;
- Obtain a copy of your paper or electronic record.
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosure of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Elect to opt out of receiving further communications to raise funds for the practice.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact **Beth at (971) 371-3120, 5025 NE Elam Young Pkwy, Suite 100, Hillsboro OR 97124** in person or in writing, during normal hours. **She** will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities
The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you;
- We will never share your information (for marketing purposes, sale of your information, sharing of psychotherapy notes) without your written permission:, and
- Notify you if you are affected by a breach of unsecured PHI

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our “Notice” or by visiting our office and picking up a copy.

To Request Information or File a Complaint
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Beth, Office Manager, (971) 371-3120**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Beth.** You may also file a complaint by mailing it to the Secretary of Health and Human Services whose street address is **500 Summer St. NE, Salem, OR 97301, (503)945-5944.**

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you don't object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures beside those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature Date