**Bluegrass Oral Surgery & Dental Implant Center**
**NEW PATIENTS' INFORMATION SHEET**

## PATIENT INFORMATION

Patient's Full Name *(First, M.I., Last):*

Date of Birth: Age: Sex: M / F Marital Status: S M W D

Mailing Address:

Home #: Cell #: Work #:

Social Security #: Driver's License #:

Employer: If Student, School Name:

Name of Pharmacy: Phone #:

Referring Dentist or Physician:

## RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: Relationship to Patient:

Date of Birth: Social Security #: Driver's License #:

Address:

Home #: Cell #: Work #:

Employer:

Emergency Contact: Home #: Work #:

## INSURANCE INFORMATION

Insurance Co.: Phone #:

Group #: Policy ID #:

Insured's Name: Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: Phone #:

Insured's Social Security #: Date of Birth: Sex: Male / Female

I hereby assign, transfer, and set over to Romeo N. Laureano, DMD all of my rights, title, and interest to medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature Date

Front & Back

# HEALTH HISTORY

Patient's Name _____ Date _____

**Answer all questions by circling Yes (Y) or No (N)**

**All responses are kept confidential**

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

_____

_____

6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, 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, or Dizziness ..... 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 Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping a 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
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, Ibuprofin? ..... Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Osteoperosis Medications ..... Y N
   - F. Steroids (Cortisone, etc.?) ..... Y N
   - G. Tranquilizers? ..... Y N
   - H. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - I. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

_____

_____

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, 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? _____
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 to 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. Are you nursing? ..... Y N
    - C. **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 _____ Doctors Initials _____

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**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 |
|---|---|---|---|
| | | | |
| | | | |

## Bluegrass Oral Surgery

## Patient Authorization or Use and Disclosure of Protected Health Information

By signing, I hereby authorize Bluegrass Oral Surgery to use or disclose protected health information (Labs, X-rays, Reports, Treatment Plans) about me to only the following people:

| Name: | Relationship: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

The authorization will expire on: Indefinitely or _____ (Date of Expiration).

- The practice will not receive payment from a third party for using or disclosing Personal Health Information (PHI).
- I may inspect or copy the PHI to be used or disclosed.
- When my information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the right to refuse to sign this authorization.
- I do not have to sign this authorization in order to receive treatment from Bluegrass Oral Surgery. I have the right to refuse to sign this authorization.
- I have the right to revoke this authorization by submitted a written request to this office.

**I wish to be contacted in the following manger (check all that apply):**

**Home telephone:** _____

- ☐ O.K. to leave a detailed message
- ☐ Just leave a call back number

**Cell Phone Number:** _____

- ☐ O.K. to leave a detailed message
- ☐ Leave just a call-back number

**Written Communication:**

- ☐ O.K. to mail medical information to my home address

**Work Phone Number:**

- ☐ O.K. to leave a detailed message
- ☐ Leave just a call-back number

****If this information should change, it is your responsibility as our patient to notify us of the changes.***

Printed Name: _____ Date/Time:_____

Patient Signature:_____ Date/Time:_____

**Bluegrass Oral Surgery & Dental Implant Center**
**Financial & Office Policies**

**Basic Policy:** Payment for all services rendered is due in full at the time of service. Office accepts cash, personal checks, and credit cards. There is a $50.00 returned check fee due and payable from you for each check payment returned to use by your bank. If this is not paid, you will be turned over to the County Attorney.

**For Patients with Insurance:** As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided the proper paperwork is provided to us. We will also assist in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort is made to closely estimate your co-payments and deductible, which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company.

**Collections**: Accounts with an unpaid balance older than 30 days will be subject to a finance charge and/or an additional billing charge per month. Further unpaid balance may result in additional collection/attorney fees.

**Managed Cared Participants:** Some benefits plans require pre-authorizations and specialist referral forms from your primary physician. Please provide the proper insurance plan identification and forms necessary prior to your visit. All co-payments or patient out-of-pocket and fees are due and payable at the time of service.

**Medicare Patients:** We **DO NOT** participate with Medicare.

**Medicaid Patients:** All patients must provide current eligibility and the necessary identifications in order to be seen in our office failure to do so will result in rescheduling the appointment until current eligibility and necessary identifications can be provided.

**Surgery Fees:** All co-payments, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Your insurance carrier may require prior authorization.

**Non-Covered Charges:** Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. To assist our patients, we offer Care Credit. Ask our front office personnel for additional information.

**Workers Compensation:** If your injury is work-related, we require the necessary insurance bulling information and employer authorization form prior to your office visit or treatment.

**Personal Injury Cases:** This office does not accept liens nor bill for auto-accident or other liability or lawsuit-related cases. The patient is responsible for services provided at the time of service.

**Follow-Up Visits:** Post-operative office visits may or may not be necessary. If you need to come back, there is no additional charge if the issue is related to your previous surgery.

**Cancellation of Appointments:** Our goal is to provide high quality of care at low cost to our patients. In fairness to other patients we must have at least 48 hours' notice when cancelling appointments. A $25.00 Cancellation Fee will be charged to your account for cancelled appointments with inadequate notice. Two or more cancellations may result in dismissal from the practice. We also reserve the right to assess a $100.00 no show fee or dismissal from the practice if you no show without notifying us prior to your appointment. If the no show fee is assessed, it is the responsibility of the patient and cannot be billed to any insurance carrier.

Signature: _____ Date: _____

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**Bluegrass Oral Surgery & Dental Implant Center**
**Romeo N. Laureano, D.M.D., P.S.C.**
**120 W. Stephen Foster, Suite 107**
**Bardstown, KY 40004**
**(502) 348-1155**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |