THE ORAL SURGERY CENTER

Have you or a member of your family been seen in our office before? ..... ❑ Yes ❑ No

PATIENT INFORMATION:

Name (Mr, Mrs, Ms, Dr) ..... Date of Birth ..... ❑ Male ❑ Female
Address .....
City ..... State ..... Zip Code .....
Home Number (.....) ..... Mobile Number (.....) .....
Employer ..... Work Number (.....) .....
Social Security # ..... Weight ..... Height ..... Age .....
If student, name of school ..... Emergency Contact (not living with you) .....
Dentist ..... Name .....
Physician ..... Telephone (.....) .....

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? .....

PRIMARY INSURANCE HOLDER INFORMATION:

Name ..... Relation to Patient .....
Address .....
City ..... State ..... Zip Code .....
Daytime Telephone (.....) .....
Employer ..... Evening Telephone (.....) .....
Social Security # ..... Date of Birth .....
Insurance Co. ..... Policy #/Group # .....

SECONDARY INSURANCE HOLDER INFORMATION:

Name ..... Relation to Patient .....
Address .....
City ..... State ..... Zip Code .....
Daytime Telephone (.....) .....
Employer ..... Evening Telephone (.....) .....
Social Security # ..... Date of Birth .....
Insurance Co. ..... Policy # / Group # .....

I WISH TO PAY MY ACCOUNT IN THE FOLLOWING MANNER:

❑ INSURANCE / INITIAL PAYMENT ❑ CREDIT CARD ❑ REQUEST INSURANCE PRE-DETERMINATION

AUTHORIZATION AND AGREEMENT

In signing this authorization and agreement, it is clearly understood that the fees of this office are set by this office and not bound by my insurance company's fee schedule. In the event that The Oral Surgery Center has a contractual agreement with my insurance company, they will abide by the obligations set forth in the contract. I hereby authorize The Oral Surgery Center to furnish to my insurance company all the information which may be requested. I acknowledge full responsibility for payment of this account and understand that any financial benefit allowed by my insurance company is solely a matter between the insurance company and myself. I further acknowledge it is not the responsibility of The Oral Surgery Center to verify any such benefits, which may be allowed. I will make payment with the understanding I will be reimbursed in the event my insurance company makes payment.

Signature of person responsible for this account .....

Printed Name ..... Date .....

8401 SEASONS PARKWAY, **WOODBURY**, **MN** 55125
7791 79TH STREET SOUTH, **COTTAGE GROVE**, **MN** 55016
2850 CURVE CREST BOULEVARD, **STILLWATER**, **MN** 55082
1610 MAXWELL DRIVE, **HUDSON**, **WI** 54016
227 MERIDIAN DRIVE, **NEW RICHMOND**, **WI** 54017
404 WISCONSIN AVENUE, **AMERY**, **WI** 54001
MINNESOTA PHONE **651 233 2140** • WISCONSIN PHONE **715 690 3040**
ALL LOCATIONS FAX **651 738 9048**

POS Reorder # 1608893

THE ORAL SURGERY CENTER
MEDICAL HISTORY FORM

NAME ..... DATE OF BIRTH .....

For the following questions check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit your responses will be reviewed and additional questions may be asked.

	Yes	No
1. Are you in good health?	❑	❑
2. Has there been any change in your general health within the past year?	❑	❑
3. My last physical examination was on		
4. Are you now under the care of a physician?	❑	❑
5. The name and address of my physician(s) is		
6. Have you had any serious illness, operation, or been hospitalized in the past five years?	❑	❑
7. Are you taking any medicine(s) including non-prescription medicine?	❑	❑
If so, what medication(s) are you taking?		
8. Do you take any illegal controlled substance/drugs?	❑	❑
9. Have you ever taken a prescription diet medication called phen-fen?	❑	❑
10. Do you routinely take prophylactic antibiotics prior to dental treatment?	❑	❑
11. Do you smoke or use chewing tobacco?	❑	❑
12. Do you have, or have you had, any of the following problems?		
a. Damaged heart valves or artificial valves, including heart murmur or rheumatic heart disease	❑	❑
b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion)	❑	❑
1. Do you have high blood pressure?	❑	❑
2. Do you have chest pain upon exertion?	❑	❑
3. Are you ever short of breath after mild exercise or when lying down?	❑	❑
4. Do your ankles swell?	❑	❑
5. Do you have inborn heart defects?	❑	❑
6. Do you have a cardiac pacemaker?	❑	❑
c. Do you have surgically placed artificial joints or other materials?	❑	❑
d. Allergies or hayfever	❑	❑
e. Sinus trouble	❑	❑
f. Asthma	❑	❑
g. Fainting spells or seizures	❑	❑
h. Persistent diarrhea or recent weight loss	❑	❑
i. Diabetes	❑	❑
j. Hepatitis, jaundice or liver disease	❑	❑
k. Condition which compromises the immune system	❑	❑
l. Thyroid problems	❑	❑
m. Respiratory problems, emphysema, bronchitis, etc.	❑	❑
n. Arthritis or painful swollen joints	❑	❑
o. Stomach ulcer or hyperacidity	❑	❑
p. Kidney trouble	❑	❑
q. Tuberculosis	❑	❑
r. Persistent cough or cough that produces blood	❑	❑
s. Persistent swollen glands in neck	❑	❑

(Continued on the back side)

	Yes	No
t. Low blood pressure	❑	❑
u. Sexually transmitted disease	❑	❑
v. Epilepsy or other neurological disease	❑	❑
w. Cancer	❑	❑
13. Have you had abnormal bleeding?	❑	❑
a. Have you ever required a blood transfusion?	❑	❑
14. Do you have any blood disorder such as anemia?	❑	❑
15. Have you ever had any treatment for cancer, a tumor or growth?	❑	❑
If you answered yes to #15, have you ever taken a medication which alters bone metabolism such as bisphosphonates?	❑	❑
a. Have you ever taken medication for osteoporosis?	❑	❑
16. Are you allergic or have you had a reaction to:		
a. Local anesthetics	❑	❑
b. Penicillin or other antibiotics	❑	❑
c. Sulfa drugs	❑	❑
d. Barbiturates, sedatives or sleeping pills	❑	❑
e. Aspirin	❑	❑
f. Iodine	❑	❑
g. Codeine or other narcotics	❑	❑
h. Latex or rubber products	❑	❑
i. Any other medications or products? (Please list)	❑	❑
17. Have you had any serious trouble associated with any previous dental treatment?	❑	❑
If so, please explain:		
18. Do you have any disease, condition, or problem not listed above that you think the doctor should know about?	❑	❑
If so, please explain:		
19. Are you wearing contact lenses?	❑	❑
20. Are you wearing removable dental appliances?	❑	❑
21. Do you have pain in or near your ears or near your jaw joints?	❑	❑
22. Does any part of your mouth hurt when clenched or feel tired upon awakening?	❑	❑
23. Do you have chronic headaches, neck, or shoulder pain?	❑	❑
24. Do you have a clicking jaw joint or other joint noise?	❑	❑
25. Have you experienced any growth or sore spots in your mouth?	❑	❑
26. Do you have any loose or sensitive teeth?	❑	❑
27. Do your gums bleed?	❑	❑
28. Is there anything you would like to discuss privately with the doctor?	❑	❑

WOMEN

29. Are you pregnant?	❑	❑
30. Are you nursing?	❑	❑
31. Are you taking birth control pills?	❑	❑

PHARMACY PREFERENCE ..... **LOCATION** .....

CHIEF DENTAL COMPLAINT .....

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I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the doctor, or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient ..... Date .....
(Parent/legal guardian if under age 18)

(Staff Initial) ..... Date .....

Patient HIPAA Acknowledgment and Consent to Share Information
The Oral Surgery Center
8401 Seasons Parkway
Woodbury, MN 55125

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 consent to the disclosure of my health records to any providers involved in my care or treatment, to health plans, to others as needed for payment purposes, to others as needed to improve the quality of my care and experience and/or to manage The Oral Surgery Center's business operations. 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 been informed by The Oral Surgery Center of the practice's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been offered a copy of the *Notice of Privacy Practices* prior to signing this consent. 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 The Oral Surgery Center restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that The Oral Surgery Center is not required to accept requested restrictions but if agreement is approved, The Oral Surgery Center is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that The Oral Surgery Center has taken action relying on this consent.

HIPAA Privacy issues can arise when using cell/smart phones in areas of The Oral Surgery Center where patients and/or patient information may end up in photos or audio recordings. Patients and/or discussions may be in the background, and this information may be picked up in the photo or audio recording.

To ensure confidentiality and privacy, the use of camera phones and personal digital assistants (PDAs) for the purpose of video-taping patients for non-clinical purposes is strictly prohibited.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Right of Access for Family Member/Friend
In addition to the disclosures outlined above, I direct The Oral Surgery Center to disclose and release my protected health information described below to:

Family Member/Friend Name: _____

Information to be Disclosed: _____

Date: _____