ORAL & MAXILLOFACIAL
SURGERY
OF OCEAN PARKWAY

Please assist us in making sure our medical history and your records are complete and accurate. Please provide the following information:

PATIENT INFORMATION

DATE: _____

PATIENT NAME _____ **DATE OF BIRTH** _____

SSN#_____ **Male**_____ **Female**_____

PATIENT ADDRESS_____

APT#_____ **ZIP**_____

PATIENT PHONE # _____ **CELLPHONE#** _____

E-MAIL _____

EMERGENCY CONTACT (Name) _____ **EMERGENCY CONTACT (Phone #)** _____

PHARMACY NAME, ADDRESS, AND PHONE NUMBER

_____

_____

PLEASE COMPLETE THE FOLLOWING:

****DID YOU DRIVE HERE:** **Yes** _____ **No** _____

****HAVE YOU EATEN OR HAD ANYTHING TO DRINK IN THE LAST SIX HOURS:** **Yes** ____ **No** ____

****IS YOUR ESCORT WITH YOU?** **Yes** _____ **No** _____

MEDICAL/DENTAL PROVIDER INFORMATION

MEDICAL DOCTOR

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

REFERRING DENTIST

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

MARK B.BIRNBAUM, D.D.S.*, NORMAN E. JOHNSON, D.D.S., STEVE MANZON, D.M.D.*, AVI FEYGIN, D.M.D.*

PRACTICE LIMITED TO ORAL AND MAXILLOFACIAL SURGERY

1777 OCEAN PARKWAY BROOKLYN, NEW YORK 11223 (718) 998-9114 / Fax: (718) 998-3727

*Diplomate, American Board of Oral and Maxillofacial Surgery

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Chart Number: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

What is the reason for today's visit? _____

I. CIRCLE APPROPRIATE ANSWER:

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. Yes No Are you being treated by a physician now?
   For what? _____
   _____
   Date of last medical exam: _____
   Date of last Dental exam: _____
5. Yes No Have you had problems with prior dental treatment?
6. **Yes No Allergies to: drugs, foods, medications, latex?**
7. **Yes No Are you taking blood thinners?**

II. HAVE YOU EXPERIENCED:

8. Yes No Chest pain (angina)?
9. Yes No Swollen ankles?
10. Yes No Shortness of breath?
11. Yes No Recent weight loss, fever, night sweats?
12. Yes No Persistent cough, coughing up blood?
13. Yes No Bleeding problems, bruising easily?
14. Yes No Sinus problems?
15. Yes No Difficulty swallowing?
16. Yes No Diarrhea, constipation, blood in stools?
17. Yes No Frequent vomiting, nausea?
18. Yes No Difficulty urinating, blood in urine?
19. Yes No Dizziness?
20. Yes No Ringing in ears?
21. Yes No Headaches?
22. Yes No Fainting spells?
23. Yes No Blurred vision?
24. Yes No Seizures?
25. Yes No Excessive thirst?
26. Yes No Frequent urination?
27. Yes No Dry mouth?
28. Yes No Jaundice?
29. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

30. Yes No Heart disease?
31. Yes No Heart attack, heart defects?
32. Yes No Heart murmurs?
33. Yes No Prosthetic heart valve, internal defibrillator, pace maker?
34. Yes No Rheumatic fever?
35. Yes No Stroke, hardening of arteries?
36. Yes No High blood pressure?
37. Yes No Asthma, TB, emphysema, other lung diseases?
38. Yes No Sleep Apnea?
39. Yes No Hepatitis, other liver disease?
40. Yes No Stomach problems, ulcers?
41. Yes No Family history of diabetes, heart problems, tumors?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No HIV+/AIDS, VD (syphilis or gonorrhea)?
46. Yes No Herpes?
47. Yes No Kidney, bladder disease?
48. Yes No Thyroid, adrenal disease?
49. Yes No Diabetes?
50. Yes No Psychiatric care?
51. Yes No Radiation treatments, tumors, cancer?
52. Yes No Chemotherapy?
53. Yes No Artificial joint? Example: hip or knee replacement
54. Yes No Hospitalizations?
55. Yes No Anemia?
56. Yes No Blood transfusions?
57. Yes No Surgeries?

IV. ARE YOU TAKING:

58. Yes No Recreational drugs?
59. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
    Please list: _____
    _____
    _____
    _____
60. Yes No Tobacco in any form?
61. Yes No Alcohol?

V. WOMEN ONLY:

62. Yes No Are you pregnant?
63. Yes No Are you nursing?
64. Yes No Taking birth control pills?

VI. ALL PATIENTS:

65. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
    If so, please explain: _____
    _____
    _____
    _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications.

Patient's signature: X _____ Date: _____

Doctor's signature: _____ 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 is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses 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:

- 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 that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- 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 disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- 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 **[insert name of designated staff member, phone number, or address]**, in person or in writing, during normal hours. S**[he]** 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;

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.

_____ _____

Name Date

- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

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 **[insert name, title, and telephone number of internal contact person].**

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 **[list internal staff member.]** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is **[insert street and e-mail addresses.]**

- 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 do not 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 besides 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.

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Office Policy

A Notice to Our Patients

Although we participate with many insurance plans, your insurance may not cover every service provided in this office. It is your responsibility to familiarize yourself with and understand the limits of your insurance coverage before seeking care.

Since we are not your insurance company, we cannot be responsible for explaining the details of your insurance policy to you. Please review your plan's coverage or contact your insurance carrier if you are uncertain about the limits of your coverage and benefits prior to your treatment.

If your insurance requires a referral from your primary care physician or your general dentist, it is your responsibility to bring us a valid, unexpired referral. No exceptions will be made.

You will be financially responsible for any service or procedure not covered in our office. Copays/fees quoted on the date of service are estimates. You may receive a bill after the date of service. By signing below, you agree to be financially responsible for any fees that you have signed a financial agreement for as well as any fees or copays that your insurance's Explanation of Benefits applied to "patient responsibility."

If you receive a bill, and your balance is not paid within 90 days of the first bill received, you may be forwarded to a collection agency and subsequently be responsible for OMFSof Ocean Parkway's legal fees, interest charges, and any other expenses incurred in collecting the balance on your account. You will be responsible to reimburse the office collection agency fees, which will be added to the account at the time it is placed with an agency for collection and may be based on a percentage at a maximum of 50% of the debt on your account.

This contract will be effective as of the signed date indicated below and will remain in effect in perpetuity.
By signing this agreement, you affirm that you have read, understand, and agree to the statements above.

_____ _____

Print Patient Name **Print** Financial Guarantor Name

X_____ _____

Patient or Financial Guarantor **Signature** Date

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HIPAA Cyber Security Waiver

In these unprecedented times of internet cyber security awareness, the OMFS Center of Ocean Parkway (further known as the 1st party), shall endeavor to use appropriate security measures to protect the confidentiality of patient information. The office employs onsite and offsite HIPAA standard encryption technologies and measures for the storage and the safe transmission of patient information. The patient, or patient's legal guardian (further known as the 2nd party), whose signature appears below, acknowledges and agrees that (I) no form of encryption is perfect, (ii) the 1st party shall not be held liable for any costs, damages or losses resulting from the 1st party's security failure and the data contained therein being compromised, and (iii) the 2nd party indemnifies the 1st party from any and all subsequent damages or losses as a result of cyber security failures by internal or external criminal activity in perpetuity.

X_____ x_____

Print Patient Name Patient or Legal Guardian Signature

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Patient Acknowledgement of the Office Policy

By initialing and signing below, I acknowledge the following:

_____1. There is no video recording or photography on the office premises by the patient or the patient's escort.

_____2. The office is not responsible the patient's belongings; it is the patient's responsibility to take proper precautions when storing property and or valuables.

_____3. Only doctors, surgical assistants, and the patient are allowed in the operatory during treatment. No exceptions will be made.

X _____ _____

Patient/Guardian Signature **Date**

Office representative:

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Notice to Patients Regarding
General Anesthesia/Sedation

According to 8 CRR-NY 61.10NY-CRR Official Compilation of Codes, Rules, and Regulations of the State of New York Title 8:

If a patient receives general anesthesia or sedation for a procedure, a responsible adult escort must be present to escort the patient from the office.

An Uber or car service driver is not responsible for the health of someone they are transporting, nor are they responsible for getting the rider into house safely and making sure the rider is okay.

By signing below, you acknowledge the need for a responsible adult escort, legally and for your safety.

X _____
Patient's **Printed** Name

X _____ _____
Patient's **Signature** Date

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