Pomona Valley Oral & Maxillofacial Surgery

MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F Height:_____Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia) ? ..... Yes No
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes No
   If so, please list: _____
   _____

10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
    b. Rheumatic Heart Disease ..... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after mild exercise? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    d. Allergies ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma or hay fever ..... Yes No
    g. Fainting spells or seizures ..... Yes No
    h. Diabetes ..... Yes No
    i. Hepatitis, jaundice or liver disease ..... Yes No
    j. Frequent or recurring mouth sores ..... Yes No
    k. Thyroid problems ..... Yes No
    l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
    n. Osteoporosis ..... Yes No
    o. Stomach ulcer or hyperacidity ..... Yes No
    p. Kidney trouble ..... Yes No
    q. Tuberculosis ..... Yes No

r. Persistent cough or cough that produces blood ..... Yes No
s. Persistent swollen neck glands ..... Yes No
t. Low blood pressure..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer ..... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

11. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin..... Yes No
    f. Iodine..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other..... Yes No
16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain:_____
    _____
17. Do you have any other condition or disease you think the doctor should know about?..... Yes No
    If so, explain:_____
18. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?..... Yes No
20. Are you wearing contact lenses?..... Yes No
21. Are you wearing removable dental appliances? ..... Yes No
22. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

20. Are you pregnant or trying to become pregnant ..... Yes No
21. Do you have problems associated with your menstrual period? ..... Yes No
22. Are you nursing? ..... Yes No
23. Are you taking birth control pills?..... Yes No

A. 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.

Chief Dental Complaint: _____
_____
_____
_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date:_____ Patient's Signature:_____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Date:_____ Doctor's Signature:_____

Medical History Update:

Date	Comments	Signature

POMONA VALLEY | ORAL & MAXILLOFACIAL SURGERY

Welcome

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in **BLACK** ink. If you have any questions or need assistance, please ask us. We will be happy to help.*
Whom may we thank for referring you to our office? _____

Patient Information (CONFIDENTIAL)

Patient's Name _____

Address_____ City_____

State _____Zip_____

Home Ph. # (____) _____Cell. # (_____) _____
Email address _____
Soc Sec #_____-_____-_____Birth date _____/_____/____Driver's lic. #_____
Employer_____Occupation _____
Employer Address _____ City_____ State_____ Zip _____
Spouse's Name _____Employer_____
Soc Sec #_____Birth date_____Work ph. #_____
Name of nearest relative _____Relationship_____
Emergency Contact_____Ph. #_____

Insurance Information

Name of Insured_____Insured's Soc. Sec. **#**_____
Insurance Company_____ Group #_____Policy/ID # _____
Insurance Address_____City_____State_____ Zip_____
Insurance Phone # (____)_____
Do you have dual coverage? [ ] Yes [ ] No If yes, Please complete the following secondary insurance information.

Name of Insured_____Insured's Soc. Sec. **#**_____
Insurance Company_____Group #_____Policy/ID #_____
Insurance Address_____City_____State_____Zip_____
Insured's Employer _____Ph. # (____) _____

Responsible Party (If a minor)

Name_____Marital status_____E-mail address_____
Billing Address_____City_____State_____Zip_____
Soc Sec #___- _____- _____ Driver's lic. **#** _____ Birth date _____/_____/__
Employer_____
Employer Address_____ City_____ State_____ Zip_____

Signature_____ Date: _____

POMONA VALLEY | ORAL & MAXILLOFACIAL SURGERY

John M. Allen, D.M.D.

1909 Royalty Drive Pomona, California 91767
Tel: (909) 623-3421 Fax: (909) 629-9520

DEPOSIT FOR SURGERY APPOINTMENT

To you, our valued patient:

In order to provide you with quality care for your surgical needs, it is necessary for Dr. Allen to commit his professional time to you. Please make appointments with us that you can commit to as well.

In order to reserve your surgery appointment, we require a $100.00 deposit, which will be applied to your surgical fees. Should you fail to keep your appointment or cancel your appointments without a minimum of a 48-hour notice, the $100 deposit will be forfeited.

If you cancel your surgical appointment at least 48 hours in advance and elect not to reschedule, you will received a refund of your $100 deposit.

Thank you in advance for your understanding and cooperation.

Name:_____

Signature:_____

Date:_____ Witness:_____

DIPLOMATE AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY
FELLOW AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS
DIPLOMATE NATIONAL DENTAL BOARD OF ANESTHESIOLOGY
FELLOW AMERICAN DENTAL SOCIETY OF ANESTHESIOLOGY
USC UNIVERSITY HOSPITAL MEDICAL STAFF
LOS ANGELES COUNTY / USC MEDICAL CENTER ATTENDING STAFF
USC SCHOOL OF DENTISTRY ATTENDIG STAFF

POMONA VALLEY | ORAL & MAXILLOFACIAL SURGERY

Medicare
Private Contract

By signing this contract I understand and agree that I will not submit (or request that my oral and maxillofacial surgeon submit) a claim to Medicare or its agents for services provided by *Dr. John M. Allen DMD*, even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by *Dr. John M. Allen DMD*, and I understand that no claims will be submitted to Medicare and no Medicare reimbursement will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral and maxillofacial surgeon for services provided.

I understand that I have the right to have services provided by other oral and maxillofacial surgeons or other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out.

I understand that *Dr. John M. Allen DMD* is not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective on _____, and it will expire on _____.
(Date) (2yrs from today)

Patient Name: _____

Patient's Signature: _____

1909 Royalty Drive Pomona, Ca 91767
(909) 623-3421
(909) 629-9520
info@pomonavalleyoms.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Source of Authority_____

NOTICE OF PRIVACY PRACTICES
John M. Allen, D.M.D.

1909 Royalty Drive Pomona, Ca 91767
(909) 623-3421
(909) 629-9520
info@pomonavalleyoms.com

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

We will ask for special written permission in the following situations: for educational and or study groups.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of *Dr. John M. Allen* Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____