SIERRA
Oral & Facial Surgery
Ryan Falke, D.D.S.

151 Ash St., Suite B
Susanville, CA 96130
P: 530.257.4455

PATIENT INFORMATION:

Today's Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME) Medical Dr. _____ (FIRST NAME) _____ (LAST NAME)

Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Ext. _____

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

PHARMACY INFORMATION:

Pharmacy Name:

Address:

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

PRIMARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

SECONDARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

SECONDARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	☐	☐
2.	Have there been any changes in your general health in the past year?	☐	☐
3.	Are you under the care of a physician? ***Date of last visit*** _____	☐	☐
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	☐	☐
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	☐	☐
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant / heart valve replacement? ***If so, describe where*** _____	☐	☐
7.	Have you ever had general anesthesia?	☐	☐
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☐

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
11. Asthma	☐	☐
12. Difficulty breathing?	☐	☐
13. Other lung problems / cough?	☐	☐
14. A Pacemaker / Heart valve replaced?	☐	☐
15. Heart problems?	☐	☐
16. Chest pain?	☐	☐
17. Irregular heart beat?	☐	☐
18. Heart surgery?	☐	☐
19. Stroke?	☐	☐
20. Trouble climbing two flights of stairs?	☐	☐
21. High or Low Blood Pressure?	☐	☐
22. Sleep Apnea / Use CPAP?	☐	☐
23. Bleeding Disorder?	☐	☐
24. Bruise / Bleed easily?	☐	☐
25. Hepatitis / Liver Disease?	☐	☐
26. Faint easily?	☐	☐
27. Seizures?	☐	☐
28. Thyroid Trouble?	☐	☐
29. Diabetes?	☐	☐
30. Kidney problems?	☐	☐
31. Dialysis?	☐	☐
32. High Cholesterol?	☐	☐
33. Arthritis?	☐	☐
34. Osteoporosis?	☐	☐
35. Prosthetic joint?	☐	☐
36. Stomach ulcers / Reflux?	☐	☐
37. Immune system problems?	☐	☐

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
38. Slow healing?	☐	☐
39. Tumor or growth?	☐	☐
40. Cancer / Radiation / Chemo?	☐	☐
41. Eye disease / glaucoma?	☐	☐
42. Mental health problems / anxiety / depression?	☐	☐
43. Developmental Delay?	☐	☐
44. Removable dental appliance?	☐	☐
45. Pain or clicking of jaws?	☐	☐
46. Contagious Disease?	☐	☐
47. Any other condition / problem not listed?	☐	☐
48. Other condition: _____		
49. Do you smoke?	☐	☐
50. # packs / day _____		
51. Do you use alcohol?	☐	☐
52. How much? _____		
53. History of illicit drug use?	☐	☐
54. History of dependence or addiction to any substance?	☐	☐

WOMEN ONLY: *(QUESTIONS 67–70)*

		Yes	No
67.	Is there a possibility of pregnancy?	☐	☐
68.	Expected delivery date? _____		
69.	Are you nursing?	☐	☐
70.	Are you taking birth control pills?	☐	☐

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO
71. Any kind of medication, drug, pills?	☐	☐
72. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?	☐	☐
73. Have you ever taken diet pills?	☐	☐
74. Any natural product, herbal supplement or homeopathic remedy?	☐	☐
75. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV– Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years?	☐	☐

76. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

77. Please list any medications you are currently taking. Use the back if necessary. Or, if you have a list, please give it to us & we will make a copy.

Medication	Dosage	Frequency
☐ None		

If you are having surgery **today**, have you had anything to eat or drink in the last 8 (eight) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe:

_____

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO
78. Local anesthetic (numbing meds.)?	☐	☐
79. Penicillin?	☐	☐
80. Other antibiotics?	☐	☐
81. Sulfa drugs?	☐	☐
82. Sodium pentothal / Valium / other tranquilizers?	☐	☐
83. Aspirin?	☐	☐
84. Amoxicillin?	☐	☐
85. Codeine or other narcotics?	☐	☐
86. Other medications?	☐	☐
87. Latex?	☐	☐
88. Soy?	☐	☐
89. Eggs / yolk?	☐	☐
90. Sulfites?	☐	☐
91. Do you have any known allergies?	☐	☐

92. Please list any allergies other than drug allergies:
☐ None

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

	YES	NO
93. Have you been prescribed narcotic pain medication?	☐	☐
94. If so, did it work as intended in the past?	☐	☐

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

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me. I understand that Sierra Oral & Facial Surgery is opted out of Medicare and I am entering a private contract for my care.

X _____ **X** _____

Signature of patient: *(Parent or Guardian if Minor)* **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

X _____

Signature of patient *(Parent or Guardian if Minor)*

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

January 1, 2018

NOTICE OF PRIVACY PRACTICES

Sierra Oral & Facial Surgery
151 Ash St. Suite B
Susanville, CA 96130
info@sierraoralsurgery.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.

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, email, text or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, email, text, or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may 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.

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 any other reason we will request your written.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____ (your name) have received a copy of this office's Notice of Privacy Practices.

_____

(Please Print Patient Name)

_____

(Your Signature)

_____

(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

_____

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Oral & Facial Surgery