Patient Intake Form

☐ Mr ☐ Mrs ☐ Ms ☐ Dr First ____________________ MI ___ Last ____________________ Nickname ________________
☐ Male ☐ Female | Social Security Number ___________________________ Date of Birth ____ / ____ / ____ Age ________
Address____ Height __________ Weight __________
City _________________________________ State ___________ Zip ____________ Email ______________________________
Home Phone _______________________ Work Phone _________________________ Cell Phone _________________________
Marital Status ☐ Single ☐ Married Spouse's Name ______________________ Driver's License # _______________________
Family/friends who have been a patient here ____

Emergency Contact

Name ____ Relationship ___________________ Phone _______________________

Employment

Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Disabled ☐ Other __________________________
Employer ____ Occupation ____________________________

Education

Student Status ☐ Full Time ☐ Part Time ☐ Other _____________________ Current Grade Level ________________________
School ____

Referral

General Dentist _______________________________________ Orthodontist ____
Primary Care Physician _________________________________ Other Healthcare Providers ______________________________
Pharmacy ____ Pharmacy Phone ____________________________________

Guarantor

Who is responsible for payment? ☐ Self ☐ Spouse ☐ Parent ☐ Other _________________ Employer ____________________
Guarantor ____ DOB __________________ SSN _______________________
Address ____ City __________________ State _________ Zip _________
Home Phone _______________________ Work Phone _________________________ Cell Phone _________________________

Insurance Information

Primary Dental Insurance ___________________________________ Policy # __________________ Group # __________________
Name of Insured ____ DOB __________________ SSN ________________________
Primary Medical Insurance __________________________________ Policy # __________________ Group # __________________
Name of Insured ____ DOB __________________ SSN ________________________
Secondary Insurance ______________________________________ Policy # __________________ Group # __________________
Name of Insured ____ DOB __________________ SSN ________________________

How did you hear about us ☐ Dentist | ☐ Friend/Family | ☐ Facebook | ☐ Print Ad | ☐ Internet Search
☐ Insurance | ☐ Other ____

I have read and understand the questions and information I provided above and on the Patient Health History following. I acknowledge that my questions, if any, about the inquiries concerning my information and/or my health history have been answered to my satisfaction. I will not hold OFS, LLC or its staff responsible for any errors or omissions that I may have made in the completion of this form.

________________________________ ___________ ________________________________ ___________
Patient/Guardian Signature Date Staff Signature Date

Patient Health History

Past Medical History (for your safety, you must answer all of the questions below to the best of your knowledge)

Do you have any known drug allergies? ☐ Yes ☐ No | list ____________________

Do you have a Latex allergy? ☐ Yes ☐ No | Do you have any food allergies? ☐ Yes ☐ No | list ____________________

Please list ALL home medications (prescriptions, over the counter medicines, vitamins, herbal/dietary supplements)

____

____

Are you taking now or have you ever taken:

- Blood thinners (Warfarin, Coumadin, Xarelto, etc) Y | N List ______________ Date last taken ____/____/____
- Bisphosphonate (Fosomax, Boniva, Reclast, etc) Y | N List ______________ Date last taken ____/____/____
- Steroids (Prednisone) Y | N List ______________ Date last taken ____/____/____
- Birth control pill or hormone replacement therapy Y | N List ______________ Date last taken ____/____/____

Are you pregnant or are you planning to become pregnant within the next year? ☐ Yes ☐ No

Do you have any chronic medical problems?

Y | N High Blood Pressure	Y | N Pacemaker	Y | N Gastric Reflux	Y | N Diabetes	Y | N Anemia
Y | N Heart Disease	Y | N Rheumatic Fever	Y | N Stomach Ulcer	Y | N Thyroid Disease	Y | N Sickle Cell
Y | N Heart Failure	Y | N Stroke	Y | N Liver Disease	Y | N Glaucoma	Y | N Bleeding Problems
Y | N Heart Attack	Y | N Seizures/Epilepsy	Y | N Hepatitis	Y | N Herpes (cold sores)	Y | N Depression
Y | N Irregular Heart Beat	Y | N Sinus Problems	Y | N G-6PD	Y | N HIV/AIDS	Y | N Mental Illness
Y | N Heart Murmur	Y | N Sleep Apnea	Y | N Kidney Disease	Y | N STD	Other ______________
Y | N Congenital Heart	Y | N Asthma	Y | N Arthritis	Y | N Migraine	Other ______________
Y | N Valve replacement	Y | N Emphysema	Y | N Artificial Joint	Y | N Cancer/Radiation	Other ______________

Past Surgical History

Please list all prior surgeries and any associated complications

____

____

Anesthesia History

Is there a personal or family history of anesthetic complications ☐ Yes ☐ No | Malignant Hyperthermia ☐ Yes ☐ No

Explain ____________________

Family History (please check all that apply)

Do you have a family history of any medical problems?

☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Liver Disease ☐ Diabetes ☐ Bleeding Problems
☐ Obstructive Sleep Apnea ☐ Lung Disease ☐ Seizures ☐ Kidney Disease ☐ Thyroid Disease ☐ Psychiatric Diagnosis

Social History

Do you or have you ever smoked tobacco products? ☐ Yes ☐ No If yes, packs/day _______ for _______ years

Do you drink alcohol? ☐ Yes ☐ No If yes, please check? ☐ Occasional ☐ Moderate ☐ Daily

Do you or have you used recreational drugs? ☐ Yes ☐ No List ____________________

Review of Systems (please check all that apply)

☐ Fever/chills ☐ Weight loss ☐ Swollen lymph nodes ☐ Easy bruising/bleeding ☐ Oral/Facial Pain ☐ TMJ Pain ☐ Rash
☐ Pain or difficulty swallowing ☐ Chest pain ☐ Irregular heartbeat ☐ Shortness of breath ☐ Nausea/vomiting
☐ Facial weakness or numbness ☐ Memory loss/confusion ☐ Frequent infections ☐ Change in vision ☐ Headache
☐ Difficulty urinating ☐ Excessive thirst Other ____________________

____________________ Patient/Guardian Signature ________ Date ____________________ Staff Signature ________ Date

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

If you have questions about this Notice, please contact:
Christie McLean
Program Administrator
747 North Dean Road
Auburn, Alabama 36830
334-749-3436

We may use and disclose your PHI in the following ways:

- Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

- Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

- Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

- Optional Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

- Optional Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

- Optional Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

- Optional Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

- Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of
  - Maintaining vital records, such as births and deaths
  - Reporting child abuse or neglect
  - Preventing or controlling disease, injury or disability
  - Notifying a person regarding potential exposure to a communicable disease,
  - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
  - Reporting reactions to drugs or problems with products or devices,
  - Notifying individuals if a product or device they may be using has been recalled,
  - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
  - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- Law enforcement. We may release PHI if asked to do so by a law enforcement official
  - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
  - Concerning a death we believe has resulted from criminal conduct,
  - Regarding criminal conduct at our offices,
  - In response to a warrant, summons, court order, subpoena or similar legal process,

Notice of Privacy Practices

- Law enforcement (continued)
  - To identify/locate a suspect, material witness, fugitive or missing person,
  - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetra tor).
- Optional Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
- Optional Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
- Optional Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions

  (A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
  (B) The research could not practicably be conducted without the waiver,
  (C) The research could not practicably be conducted without access to and use of the PHI.
- Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
- Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
- Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

You have the following rights regarding the PHI that we maintain about you:

■ Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Christy McLean – Program Administrator specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

■ Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Christie McLean, Program Administrator – 334-749-3436. Your request must describe in a clear and concise fashion

- The information you wish restricted
- Whether you are requesting to limit our practice's use, disclosure or both
- To whom you want the limits to apply

■ Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Ashley Craft, Program Administrator – 3340749-3436 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

■ Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Ashley Craft, Program Administrator – 334-749-3436. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

■ Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Christie McLean, Program Administrator – 334-749-3436. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

■ Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Christie McLean, Program Administrator – 334-749-3436.

■ Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Christie McLean, Program Administrator – 334-749-3436. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

■ Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Effective August 15, 2017.

Notice of Privacy Practices Acknowledgment
Authorization for Marketing Communications

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that by signing this consent I authorize OFS, LLC (OFS) to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that OFS has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name (Printed)	Patient Signature (parent/guardian if minor)	Relationship to patient	Date

OFFICE USE ONLY

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

Date ________________ Reason ________________________________ Staff ________________

Personal Representative Designation

Federal law states that OFS cannot share your health information without your permission except in certain situations. If you sign this form, you are giving OFS permission to treat the person(s) you name as your Personal Representative, and to share your health information with that person. You can name more than one person as your Personal Representative. This Personal Representative Designation will remain in effect until the Revocation section is signed and submitted to OFS. Revocations or changes to this designation will not apply to information that has already been released by OFS. I understand this designation is voluntary and is being made at my request. I name the following person(s) to act as my Personal Representative:

Name	DOB	Relationship to patient	Name	DOB	Relationship to patient

☐ This person(s) has all the rights that I have regarding my health information maintained by OFS.

☐ This person(s) is acting as my Personal Representative only for these functions: ________________________

Patient Signature (parent/guardian if minor) ________________________________ Date ________________

REVOCATION: I no longer want the person(s) named above to act as my Personal Representative.

Patient Signature (parent/guardian if minor) ________________________________ Date ________________

OFS values you as a patient and respects the privacy of your personal and medical information that is disclosed to us in the course of our treatment relationship with you. The law allows us to send written communications to you about treatment and health care operations, including products and services we offer. This is a normal part of our provider-patient relationship, and no permission is required for us to do so. We believe such communications are a valuable part of our relationship with you. However, certain types of communications cannot be sent to you unless you provide written authorization to receive them such as information regarding additional services or products that we offer in our office.

☐ I agree to allow OFS to use my name, mailing address, phone numbers and/or email address for the purpose of contacting me or sending me materials for internal marketing. My information will not be shared with a Third Party unless additional consent is obtained.

Patient Signature (parent/guardian if minor)	Date

Consent for Photography/Videography

I have been advised that photographs and/or videos will be taken of me or parts of my body before and after surgery. The photographs and/or videos will be taken by one of the members of the OFS, LLC medical staff.

I have been provided the opportunity to ask questions concerning medical photography/videography and understand that refusal to consent will not affect my medical care.

I will not be identified by name in any of the media described; however, I also understand that in some circumstances the photographs, slides, or video may display features that identify me. My consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party without my express written permission.

I release and discharge OFS, LLC, any employees of OFS, LLC and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs/videos and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication.

I hereby give my consent for OFS, LLC to use the photographs/video under one or more of the following circumstances: (Initial all that apply)

______ Medical Record: The use of my medical images for medical records includes recording and saving images in the print or digital record for office use. My images will be kept confidential within my personal medical history file at OFS, LLC.

______ Consultation Services: The use of my medical images for consultation purposes includes sharing of these images with other healthcare providers who are involved in the diagnosis and treatment of my conditions.

______ Education: The use of my medical images for teaching purposes includes the use of my images for teaching medical students, medical residents, practicing physicians and other healthcare professionals. This includes, but is not limited to publications and presentations both in print and in electronic format.

______ Marketing: The use of my medical images for the marketing purposes includes the use of my images in print, electronic, or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television

I have the right to revoke this authorization at any time. Revocation must be provided in writing and should be presented to OFS, LLC at 747 North Dean Road, Auburn, Alabama 36830. Revocation will take effect 60 days after being received and shall not affect any release of information made prior to revocation in reliance upon this Authorization.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photography/videography consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

____
Patient Name (Printed)

______________________________ ______________________________
Patient Signature Date

If patient is unable to consent on his/her own behalf, then a parent/guardian must sign below

______________________________ ______________________________
Parent/Guardian Signature Relationship to Patient

______________________________ ______________________________
Witness Signature Date

Smoking Risk Consent Form

Patient Name ____ Date of Birth _______________ Age _____

Please indicate your current status by initialing next to the correct statement below

_____ I am a non-smoker and do not use nicotine products. I understand the potential risk of second-hand smoke exposure causing surgical complications.

_____ I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

_____ I have smoked and stopped approximately _____ months (or) _____ years ago.

Any medical or dental surgical procedure carries an element of risk for complications and or failure. Risk factors can vary greatly from patient to patient. Smoking has been documented in the literature to delay wound healing and therefore increase the risks of complications and failure. I am aware that use of tobacco / nicotine products may increase my risk of failure and post-operative complications including but not limited to pain, swelling, infection and potential loss of implants. I acknowledge and fully understand I will be responsible for any added expenses for revisions or prolonged post-operative care.

____
Patient Name (Printed)

___________________________________ ___________________________
Patient Signature Date

___________________________________ ___________________________
Physician Signature Date