Bedford Associates in Oral and Maxillofacial Surgery
Dr. John P. McPhillips, D.D.S., M.D.

Patient Information Form:

First Name: _____ Last Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Social Security #: _____Sex: Male or Female

Address: _____ City: _____ State: _____ Zip code: _____

E-mail Address: _____

Primary Phone #: _____ Secondary Phone #: _____

Employer: _____ Occupation: _____

Are you a student? **Y** or **N**, if yes, what school do you attend? _____

Who is your? Dentist: _____ Orthodontist: _____ Physician: _____

What is the reason for todays visit? _____

How did you hear about us? ○Dentist ○Orthodontist ○Physician ○Insurance ○Website ○Family/Friend ○Facebook ○Other

_____

Responsible Party For Account Balance: ***Patients who are 18+ years old are responsible for their own account****
*** Patients who are 17 years old or under, must have their parent/guardian fill out the information below***
*** The parent/guardian who accompanies their minor/child are responsible for their minor/child's account balance***

First Name: _____ Last Name: _____ Nickname: _____

Date of Birth: _____ Social Security #: _____ Sex: Male or Female

Address: _____ City: _____ State: _____ Zip code: _____

E-mail Address: _____

Primary Phone #: _____ Secondary Phone #: _____

Relationship to patient: _____

In the event a family member or caregiver attends your office visit and is in the exam room at the time of your evaluation and/ or treatment, I give Bedford Associates in Oral and Maxillofacial Surgery permission to discuss my condition, treatment, or diagnosis with that person. ○ Yes ○ No

With whom may we discuss or release information about your care, treatment, or diagnosis?

_____ Relationship: _____

_____ Relationship: _____

With whom may we NOT discuss or release any information about your care, treatment, or diagnosis?

_____ Relationship: _____

Signature: _____ Date: _____

Printed Name: _____

Bedford Associates in Oral and Maxillofacial Surgery – Medical History Form

Patient Name: **Date of Birth:**

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N). ALL RESPONSES ARE KEPT CONFIDENTIAL

1. Are you in good health **Y** **N**

2. Has there been any change in your general health in the past year **Y** **N**

3. Date of last exam:

4. Are you now under a physicians care **Y** **N**

5. **List all operations and hospitalizations:**

6. Do you have or have you had:

A. Adverse effects from dental treatment **Y** **N**

B. Jaw joint pain or popping **Y** **N**

C. Sleep apnea **Y** **N**

D. Congenital heart disease, heart murmur, rheumatic heart disease, heart surgery, chest pain, angina, heart attack, palpitations, high blood pressure, stroke **Y** **N**

E. Lung Disease: asthma, emphysema, bronchitis, pneumonia or tuberculosis **Y** **N**

F. Seizures, epilepsy, mental retardation, psychiatric treatment or Alzheimer's **Y** **N**

G. Bleeding disorder, bleeding tendency, blood transfusion, or anemia **Y** **N**

H. Liver Disease: Jaundice, Hepatitis **Y** **N**

I. Kidney Disease **Y** **N**

J. Diabetes **Y** **N**

K. Thyroid Disease (Goiter) **Y** **N**

L. Arthritis **Y** **N**

M. Osteoporosis **Y** **N**

N. Reflux, stomach ulcers, colitis **Y** **N**

O. Glaucoma **Y** **N**

P. Sinus or nasal problems or allergies **Y** **N**

Q. Cancer **Y** **N**

R. Radiation (x-ray) treatment for cancer **Y** **N**

S. Implants placed anywhere in your body (heart valve / hip or knee replacement) **Y** **N**

T. Any other disease or disorder not listed above
Please list:

7. Are you using or taking any of the following:

a. Antibiotics **Y** **N**

b. Anticoagulants (blood thinners) **Y** **N**

c. Steroids (cortisone, etc) **Y** **N**

d. Insulin or oral medication for diabetes **Y** **N**

e. Bisphosphonates for osteoporosis or cancer (currently or in the past) Fosamax, Actonel, Boniva, Reclast, Aredia, Zometa **Y** **N**

f. Aspirin or NSAID (ibuprofen, motrin, advil, aleve, etc.) **Y** **N**

g. marijuana or other "street drugs" **Y** **N**

h. **list all medications you take:**

8. Are you allergic or have you had a bad reaction to:

a. general anesthesia, sedatives or local anesthetics **Y** **N**

b. penicillin, amoxicillin, cephalosporin or other antibiotics **Y** **N**

c. aspirin or ibuprofen **Y** **N**

d. codeine or other pain medications **Y** **N**

e. latex **Y** **N**

f. other allergies or reactions **Y** **N**

Please list:

9. Do you smoke, chew or dip tobacco **Y** **N**

10. Do you have or have you had an alcohol or drug dependence **Y** **N**

11. **FOR WOMEN ONLY**

A. If you are using oral contraceptives, it is important that you understand that antibiotics and 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 medications is completed. Please contact your physician for further guidance.

B. If you are pregnant, possibly pregnant or trying to become pregnant; anesthesia and other medications may significantly harm your developing baby, especially during the first trimester. **PLEASE ADVISE YOUR DOCTOR IF THERE IS ANY CHANCE OF YOU BEING PREGNANT!**

C. Are you pregnant? **Y** **N**

D. Are you nursing? **Y** **N**

I UNDERSTAND THE IMPORTANCE OF AN ACCURATE HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY **DATE** DOCTOR'S INITIALS

Bedford Associates in Oral and Maxillofacial Surgery

Insurance / Financial Form:

Patient Name: _____

Dental Insurance Information:	Medical Insurance Information:
Who Is Insured?: Patient (Myself) / Spouse / Parent (Circle One)	Who Is Insured?: Patient (Myself) / Spouse / Parent (Circle One)
Name of Insured:	Name of Insured:
Birthday of Insured:	Birthday of Insured:
Social Security # of Insured:	Social Security # of Insured:
Employer of Insured:	Employer of Insured:
Insurance Company Name:	Insurance Company Name:
Insurance Company Phone #:	Insurance Company Phone #:
Subscriber ID:	Subscriber ID:
Group #:	Group #:

MISSED APPOINTMENTS/CANCELLATIONS: Twenty-four (24) hour notice is required for cancellation of appointments. We reserve the right to charge a fee ($50) for missed appointments. If repeated no shows, missed, or canceled appointments occur, you will be discharged from care.
Please initial_____

PAYMENT OPTIONS:

1. Cash
2. Visa, Master Card, Discover, and American Express
3. Care Credit: If qualified, offers patients a line of credit to cover you or your family's dental care needs.
4. Wells Fargo Health Advantage: If qualified, offers patients a line of credit to cover you or your family's dental care needs.

PLEASE READ THIS CAREFULLY

You are entering into an agreement with the doctor, in which, the doctor agrees to treat the patient with the highest quality of care and the patient agrees to pay the treatment cost. As a courtesy we will assist you by filing your claim to your insurance(s) company(s) for all office visits. On the day of surgery, you will pay your estimated portion of the treatment. Please keep in mind; this amount is based on what your insurance company has estimated they will pay for the treatment. **These are only estimates and are not always accurate. If your insurance company misquotes our office, we are NOT responsible for their mistake and you will be billed for any amount your insurance company does not pay.** A pre-treatment estimate can be sent by our office and is the most accurate estimate that can be obtained from your insurance company. If you would like to wait on a pre-treatment estimate, please inform the front office before you leave. Once insurance has paid, you will be billed or refunded accordingly.

I authorize the release of any information and I assign benefits to the doctor. By signing below, I agree to the above terms of financial responsibility and understand I am responsible for any remaining balance on my account that my insurance does not cover.

_____ _____

Signature of Patient or Authorized Representative Date

Bedford Associates in Oral and Maxillofacial Surgery

Acknowledgement of Receipt of Notice of Privacy Practices

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

_____
{Print Name}

_____
{Signature}

_____
{Date}

*** Please review the Notice Of Privacy Practices on the next page. The privacy of your health information is important to us!**

Bedford Associates in Oral and Maxillofacial Surgery

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can obtain access to this information. The privacy of your health information is important to us.

Our Legal Duty:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/16/2003 and will remain In effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the new changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the Information listed at the end of this Notice.

Uses and Disclosures of Health Information:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: If you give us authorization, you may revoke it in writing at any time. Your revocation, will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for law intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights:

Access: You have the right to look at or get copies of your health information with limited exceptions. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website and would prefer a paper version. Please notify our front office staff for another copy.

If you want more information about our privacy practices or have questions or concerns, please contact us.

We support your right to the privacy of your health information.

Thank you for your business!