Patient Health Record

The information on this form is necessary for our records. It is strictly confidential. Please complete all parts.

NAME _____ _____ DATE OF BIRTH _____
First MI Last Preferred name

HOME ADDRESS _____
Street City State Zip

PREFERRED PHONE (_____)_____ ALTERNATIVE PHONE (_____)_____
□Cell □Work □Home □Other_____ □Cell □Work □Home □Other_____

SEX (ASSIGNED AT BIRTH): □Male □Female GENDER: _____ PRONOUNS: _____

MARITAL STATUS: □Single □Married □Other _____

EMAIL _____ SOCIAL SECURITY NUMBER _____

PHYSICIAN _____(_____)_____ DATE OF LAST PHYSICAL _____
Name Phone

PERSON FILLING OUT FORM _____ PERSON RESPONSIBLE FOR ACCOUNT _____
Name Relationship Name Relationship

EMERGENCY CONTACT _____(_____)_____
Name Relationship Phone

MEDICAL INFORMATION

Check DK if you don't know or are unsure of the answer.

Do you have active tuberculosis (TB)?.....□Yes □No □DK
Do you have a persistent cough that has lasted for longer than 3 weeks?.....□Yes □No □DK
Do you have a cough that produces blood?.....□Yes □No □DK
Have you recently been exposed to someone with active tuberculosis (TB)?.....□Yes □No □DK
If you answered yes to any of the above questions, please stop and return this form to the receptionist.

Have you ever had or been treated for?

Damaged heart valve……..□Yes □No □DK
Prosthetic heart valve……..□Yes □No □DK
Infective endocarditis……..□Yes □No □DK
Congenital heart disease/defect……..□Yes □No □DK
Organ transplant……..□Yes □No □DK
HIV/AIDS……..□Yes □No □DK

Have you been diagnosed and/or treated for the following conditions in the <u>last 3 years</u>?

Hypertension (HTN).....□Yes □No □DK
Angina (chest pain).....□Yes □No □DK
Heart attack…….....□Yes □No □DK
Irregular heartbeat/murmur.....□Yes □No □DK
Heart failure.....□Yes □No □DK
High cholesterol.....□Yes □No □DK
Heart infection.....□Yes □No □DK
Stroke.....□Yes □No □DK
Anemia.....□Yes □No □DK
Abnormal bleeding/use of blood thinner.....□Yes □No □DK
Sinus issues.....□Yes □No □DK
Asthma.....□Yes □No □DK
Emphysema/bronchitis……..□Yes □No □DK
Sleep apnea……..□Yes □No □DK
Difficulty breathing.....□Yes □No □DK
Diabetes.....□Yes □No □DK
□Type I □Type II
Delayed healing.....□Yes □No □DK
Hyperthyroidism.....□Yes □No □DK
Hypothyroidism.....□Yes □No □DK
Kidney disorder……..□Yes □No □DK
Are you on dialysis?.....□Yes □No □DK
Immune deficiency.....□Yes □No □DK
Are you on a steroid?.....□Yes □No □DK
Fibromyalgia.....□Yes □No □DK
Lupus……..□Yes □No □DK
Sjogren's Syndrome.....□Yes □No □DK
Arthritis.....□Yes □No □DK
Artificial joint……..□Yes □No □DK
Osteoporosis.....□Yes □No □DK
Have you taken a bisphosphonate?.....□Yes □No □DK
Acid reflux/GERD.....□Yes □No □DK
Irritable bowel syndrome (IBS).....□Yes □No □DK
Stomach ulcer.....□Yes □No □DK
Liver disease……..□Yes □No □DK
Jaundice.....□Yes □No □DK
Hepatitis.....□Yes □No □DK
Epilepsy/seizures……..□Yes □No □DK
Parkinson's Disease.....□Yes □No □DK
Multiple sclerosis……..□Yes □No □DK
Migraines/frequent headaches.....□Yes □No □DK
Hives/skin rash……..□Yes □No □DK
Glaucoma.....□Yes □No □DK
Impaired vision.....□Yes □No □DK
Impaired hearing.....□Yes □No □DK
Bipolar disorder……..□Yes □No □DK
Depression.....□Yes □No □DK
Anxiety.....□Yes □No □DK
Eating disorder.....□Yes □No □DK
Sleep disorder……..□Yes □No □DK
Dementia……..□Yes □No □DK
Learning disorder.....□Yes □No □DK
Sexually transmitted disease (STD).....□Yes □No □DK
Cancer.....□Yes □No □DK
Tobacco use.....□Yes □No □DK
Type _____ How much _____
Chemical dependency.....□Yes □No □DK
Street/recreational/ illicit drug use.....□Yes □No □DK

Do you have an <u>allergy</u> or sensitivity to any of the following?

□Local anesthetic
□Antibiotics
Please list _____
□Aspirin
□Advil (ibuprofen)
□Tylenol (acetaminophen)
□Codeine/narcotics
□Metals
□Latex
□Other _____

FEMALES ONLY: Are you currently:

Pregnant?……..□Yes □No □DK
Due date _____
Breastfeeding?……..□Yes □No □DK

Have you been told you need to take an antibiotic premedication ("premed") prior to dental treatment?.....□Yes □No □DK

For what? _____

Please list any disease, condition, or problem you have been diagnosed with and/or treated for in the <u>last 3 years</u> that is not listed above.

Please list any hospitalizations or surgeries you have had in the <u>last 3 years</u> and when they occurred.

Please list all <u>medications</u> you are currently taking (attach an additional sheet of paper if necessary).

DENTAL INFORMATION

Reason for today's visit: _____
Dental history:

Last dental visit _____
Date Location Reason

Last dental x-rays _____
Date Location Reason

Last teeth cleaning _____
Date Location

To the best of my knowledge, the preceding information is complete and correct.

_____ _____
Patient signature (or parent/guardian if patient is under 18) Date

OZ
FAMILY DENTISTRY

1550 E Adams Street • Mankato MN 56001 • Phone 507-387-2603 • Fax 507-387-4112 • www.ozfamilydentistry.com

Written Financial Policy

Thank you for choosing OZ Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. Part of that mission is to help you plan for the cost of your care by making our financial policies as clear as possible. Please read this form and feel welcome to ask any questions you might have.

Payment Options:

All payment is due on the day that treatment is completed.

- Dental Insurance
  - We are happy to work with your carrier to maximize your benefits. We will bill them directly for their portion of your treatment fees*1*.
  - Your portion of the total fee will be estimated based on your insurance coverage. This payment will be due on the day of your appointment*2*.
- Care Credit Financing
  - We do not want financial concerns to be a barrier in obtaining the services you may want or need. Accordingly, we offer a range of monthly payment plans facilitated by Care Credit. These include:
    - Zero Interest Plans from 6-12 months*3*
    - Fixed-Rate, Extended Payment plans, from 18-60 months.
    - These plans have no annual feels or pre-payment penalties. They are subject to credit approval.
- For patients who are not using insurance or Care Credit, payment will be due in full at the end of each appointment for the work that was completed that day.

Please note:

OZ Family Dentistry requires payment at the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund, less the cost of care received.

If you miss or cancel an appointment without a 48 hour notice a fee of $50 may be applied to your account.

OZ Family Dentistry charges $50 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

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1 *If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits from your carrier.*

2 *After we receive payment from your insurance, if we find you have overpaid, you will be refunded the appropriate amount. If there has been an underpayment, you will be billed for the difference.*

3 *If payment is made in full within the promotional period. Otherwise interest will be assessed from the beginning date of the loan.*

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____ **E-MAIL:** _____

PATIENT NUMBER: _____ **SOCIAL SECURITY #:** _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Shannon Kopesky, Patient Care Specialist

Telephone: 507-387-2603

Fax: 507-387-4112

E-mail: drosdoba@hickorytech.net

Address: 1550 East Adams Street, Mankato, Minnesota 56001

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE (PRINT NAME)

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. 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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice was updated 7/14/2016 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 changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In order to use your health information for any purpose not permitted by HIPAA and described in this Notice, we must obtain your written authorization. If you give us an 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.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, but 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 to such uses or disclosures. In the event of your absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information to market third-party products or services to you, or to allow third parties to send you 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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an 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).

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. 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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $ 0.20 for each page, $20.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. 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 or our business associates disclosed 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid in full by you or by a third party on your behalf.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health inforamtion as required by law.

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer	Dr. Eric Page
Telephone	507-387-2603
Fax	507-387-4112
E-Mail	drpage@ozfamilydentistry.com
Address	1550 East Adams Street, Mankato, MN 56001

.....Oz.....
FAMILY DENTISTRY
1550 E Adams Street ● Mankato MN 56001 ● Phone 507-387-2603 ● Fax 507-387-4112 ● www.ozfamilydentistry.com

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

By signing this form, I am authorizing the release of dental records for:

Name(s) of Patient *Date Of Birth*

_____

_____

_____

_____
Signature of Patient or Responsible Party

Notes: _____

_____

_____ Please send the records to Oz Family Dentistry at the address shown on this letterhead

_____ Please e-mail the records to: thefrontdesk@ozfamilydentistry.com

Thank you.