ADVANCED
ORAL SURGERY

Patient Registration Form

Date:_____

General Information

Patient Name:_____ Birth Date: _____
First MI Last

Social Security Number:_____Age:_____Gender:_____ Ht:___ft____in_Wt:_____Marital Status:_____

Address: _____
Number & Street/Apt # City State Zip

Home Phone: _____Cell Phone: _____Email Address: _____

Parent/Guardian(If Minor)_____

We would like to stay connected with you!
We understand the importance of your privacy and want to assure you that our office does not share your contact information with any third-party vendor. We would like to communicate with you regarding appointments, billing and insurance, share educational newsletters and promotions.
☑ *Please check the box and sign below if you agree to receive emails and texts from our office.*

*Signature of Patient/Guardian:*_____*Date:*_____

Name of Referring Doctor: _____Phone Number:_____

General Dentist:_____Phone Number:_____

Physician:_____Phone Number_____

Primary Insurance Carrier:_____ Insurance Phone Number:_____
Policy Holder's Name:_____Birth Date:_____

Policy Holder's SS#:_____I.D. Number:_____Plan Group Number:_____

Secondary Insurance Carrier:_____ Insurance Phone Number:_____

Policy Holder's Name:_____Birth Date:_____

Policy Holder's SS#:_____I.D. Number:_____Plan Group Number:_____

Responsible Party Information

Name of Person Responsible for Account:_____Relationship to Patient:_____

Permission to Disclose Information

As our patient, we will maintain confidentiality regarding any financial or medical conditions or treatments performed.
Please list any person, if any, you will allow us to discuss appointment details and/or payment details with.

Name of Person:_____Relationship to Patient:_____

Name of Person:_____Relationship to Patient:_____

Please sign below acknowledging your consent

Signature of Patient/Responsible Party:_____Date:_____

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Have you ever been diagnosed with any of the following conditions?

1. Y ◯ N ◉ Lung Disease
2. Y ◯ N ◯ Asthma
3. Y ◯ N ◯ COPD
4. Y ◯ N ◯ Sleep Apnea
   Do you use a CPAP? N/A
5. Y ◯ N ◯ Covid-19
   Were you hospitalized? N/A
   Do you have residual effects like lung (breathing issues) or heart problems? No
   *Please explain:*_____
   Do you have any loss of taste or smell? N/A
6. Y ◯ N ◯ Tumor and/or Malignancy
7. Y ◯ N ◯ HIV/AIDS
8. Y ◯ N ◯ Low Blood Pressure
9. Y ◯ N ◯ High Blood Pressure
10. Y ◯ N ◯ High Cholesterol
11. Y ◯ N ◯ Glaucoma
12. Y ◯ N ◯ Diabetes
13. Y ◯ N ◯ Hay Fever
14. Y ◯ N ◯ Anemia
15. Y ◯ N ◯ Tuberculosis
16. Y ◯ N ◯ Thyroid Disease
17. Y ◯ N ◯ Jaundice
18. Y ◯ N ◯ Liver Disease
19. Y ◯ N ◯ Hepatitis
    *Type*_____
20. Y ◯ N ◯ Kidney Disease
21. Y ◯ N ◯ Ulcers
22. Y ◯ N ◯ Fainting Spells
23. Y ◯ N ◯ Immune Suppressed Disorder
24. Y ◯ N ◯ Rheumatic Fever
25. Y ◯ N ◯ Hearing Loss
26. Y ◯ N ◯ Epilepsy/Seizures
    *When was your last episode?*_____
27. Y ◯ N ◯ Prolonged Bleeding Disorder
28. Y ◯ N ◯ Sexually Transmitted/Venereal Disease
29. Y ◯ N ◯ Herpes
30. Y ◯ N ◯ Heart Disease
31. Y ◯ N ◯ Mitral Valve Prolapse
32. Y ◯ N ◯ Congestive Heart Failure
33. Y ◯ N ◯ Heart Murmur

Have you ever had any of the following?

34. Y ◯ N ◯ Cancer
    *If yes, what year?*_____
35. Y ◯ N ◯ Chemotherapy
    *If yes, when?*_____
36. Y ◯ N ◯ Radiation
    *If yes, when?*_____
37. Y ◯ N ◯ Coronary Heart Stent(s)
    *How many were placed?*_____
    *When were they placed?*_____
38. Y ◯ N ◯ Excessive Urination or Thirst
39. Y ◯ N ◯ Are you taking or have you taken in the past Bisphosphonates or similar drugs? *(Prolia, Boniva, Actonel, Aredia, Zometa, Xgeva, Fosamax, etc.)*
40. Y ◯ N ◯ Do you smoke or chew tobacco?
41. Y ◯ N ◯ Do you smoke, vape, or use any marijuana product?
42. Y ◯ N ◯ Do you have a history or do you currently use recreational drugs (such as marijuana, cocaine or Methamphetamines?)
    If yes, when did you last use any of these drugs?
    _____
43. Y ◯ N ◯ Have you had a major surgery?
    Please explain: _____

Are you allergic to any of the following?

44. Y ◯ N ◯ Aspirin
45. Y ◯ N ◯ Ibuprofen
46. Y ◯ N ◯ Sulfa Drugs/Sulfites/Sulfides
47. Y ◯ N ◯ Penicillin
48. Y ◯ N ◯ Codeine
49. Y ◯ N ◯ Latex
50. Y ◯ N ◯ Adhesive Tape, metals, plastics
51. Y ◯ N ◯ Local Anesthetic (Novocain, Lidocaine, etc)

Please list any additional allergies in the section below

Women:

52. Y ◯ N ◯ Are you taking birth control medications?
53. Y ◯ N ◯ Are you or could you be pregnant?
54. Y ◯ N ◯ Are you nursing?

If further explanation was needed for any of the questions above, or you have any other condition not listed here that you would like us to know, please list here:_____

_____

_____

_____

Please list all medications you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Acknowledgements

_____I certify that the information I provided is true and accurate, and that there have been no omissions from my medical history.
Initials

_____I consent to the taking of clinical photographs during diagnostic and surgical procedures for the use of treatment, educational or research purposes.
Initials

_____I authorize the release of any medical or other information necessary to process insurance claims and authorize payment of benefits to the treating physician/dentist.
Initials

Patient/GuardianSignature:_____Date:_____

HIPAA Compliance

I hereby acknowledge that I have received from Advanced Oral Surgery, Bakersfield a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how my personal health information may be used and/or disclosed both with and without my authorization. I further understand that I may contact the HIPAA Coordinator if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices.

Patient/Guardian Signature: _____Date:_____

Statement of Financial Responsibility

I agree to be financially responsible for all services rendered by the treating physician/dentist. A payment on the account or an insurance co-payment may be due at the time services are rendered. I will be financially responsible for all charges not covered by the insurance company. I agree to pay all financial obligations in a timely fashion. I will pay all financial obligations in a timely fashion. I accept that all delinquent accounts will bear interest at the legal rate, but that special financial arrangements can be made in certain circumstances.

I understand that a percentage of the surgery may be covered under the dental or medical insurance plan. I understand that all efforts will be made to determine benefits and co-payment information prior to my treatment. I understand that I will be responsible for all co-payments, deductibles, and non-covered procedures on or before the day of surgery. In the event that the insurance company denied a claim after a procedure has been completed, I understand that I will be responsible for the balance on the account.

Responsible Party Signature:_____Date:_____

Relationship to Patient:_____

Employee
Witness:_____Date:_____

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.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as California privacy laws, we are required to maintain the privacy and security of your health information. We are also required to post in a clear and prominent location, and provide patients with this Notice of Privacy Practices, which details our privacy practices, our legal duties, and your rights concerning your health information. This Notice is currently in effect 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 law. If changes are made, a new Notice of Privacy Practices will be displayed in our office and will be 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

The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations, which include quality assurance, disease management, training, licensing, and certification programs.
- **Other Authorizations:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.
- **Family Members, Friends, and Others Involved in Care:** Only if you agree that we may do so, we may disclose your health information to a family member, friend, or other person if necessary to assist with your treatment and/or payment for services. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to sue uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards, or letters. We will use unencrypted email for communicating with you at your specific request only.
- **Legal Requirements:** We may disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse, neglect, or domestic violence is reasonably suspected, we may use or disclose your health information to the appropriate authorities to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **National Security:** When required, we may disclose to military authorities the health information of Armed Forces personnel. Information may be given to authorized federal officials when required for intelligence, counterintelligence, and national security activities. Under certain circumstances, we may disclose health information of inmate(s) to correctional institutions or law enforcement officials having lawful custody of the inmate(s).

- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Public Health Activities:** We may disclose medical information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition.
- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, access, use or disclosure.

PATIENT RIGHTS

- **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.

  We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request x-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.
- **Accounting of Disclosures:** 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. 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 will keep your information confidential from your health plans if you pay in cash, at your request. In some instances, we may not be 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 must explain the reason for the amendment.) We may deny your request under certain circumstances.
- **Electronic Notice:** If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address 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 HHS.

HIPAA Coordinator: Karina Diaz Dominguez

Telephone: (661) 863-9995 Fax: (661) 863-9996

Email: Karina@securitymedical.us

Address: 5555 Truxtun Ave Suite 200 Bakersfield, CA 93309