LOUDOUN ORAL & MAXILLOFACIAL SURGERY

Loudoun Oral & Maxillofacial Surgery
44340 Premier Plaza, Suite 100
Ashburn, VA 20147
703-729-8700
LoudounOMS.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /	Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employer's Name:	Employer's Phone: - -

Student Status:	School Name (if a full-time student):

Dentist Name:	Dentist's Phone:	Physician Name:	Physician's Phone:

Please tell us where you heard about us (check all that apply):

❑ My Dentist ❑ My Physician ❑ Friend or Relative ❑ Insurance Company ❑ Our Website
❑ Search Engine (Google, etc.) ❑ Other Website: ❑ Other:

Was our website a factor in your decision to visit our practice? ❍ Yes ❍ No

Person Responsible for Account (must be present at the appointment)

❑ Check if the patient is the person responsible for the account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy): / /	Social Security #: - -	Driver's Licence State & #:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Billing Address:	City:	State:	ZIP Code:

Employer's Name:	Employer's Phone: - -

Employer's Address:	City:	State:	ZIP Code:

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Emergency Contact

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone:	Work Phone:	Cell Phone:
- -	- -	- -

Authorized Persons

By signing below, you authorize us to discuss your medical and/or financial records with the persons listed.

First Name:	Last Name:	Relationship to Patient:	Phone:
			- -
First Name:	Last Name:	Relationship to Patient:	Phone:
			- -

Insurance Information

Dental Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insurance Company's Address:	City:	State:	ZIP Code:

Medical Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insurance Company's Address:	City:	State:	ZIP Code:

Payment Policies

Payment is due at the time of service unless alternative arrangements have been made in advance.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a $30.00 service fee.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

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Medical History

Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent any unnecessary complication during your treatment. Please mark any condition that you have currently or have been treated for in the past.

Cardiovascular (Heart)

- ❏ High blood pressure
- ❏ Heart attack
- ❏ Angina (chest pain)
- ❏ Congestive heart failure
- ❏ Irregular heart beat (ie A-fib, SVT)
- ❏ Cardiac pacemaker or defibrillator
- ❏ Heart murmur
- ❏ Mitral valve prolapse
- ❏ Damaged heart valve
- ❏ Heart valve replacement
- ❏ Endocarditis (heart infection)
- ❏ Congenital heart defect
- ❏ High cholesterol

Endocrine

- ❏ Diabetes ❏ Takes insulin?
- ❏ Thyroid disease
- ❏ Hypoglycemia

Gastrointestinal

- ❏ GERD (acid reflux)
- ❏ Chron's disease
- ❏ Ulcers
- ❏ Hiatal hernia
- ❏ Hepatitis
- ❏ Cirrhosis

Hematologic (blood disorders)

- ❏ Anemia
- ❏ Sickle cell anemia
- ❏ Hemophelia
- ❏ Von Willebrands disease
- ❏ Taking blood thinners (e.g., Coumadin, Plavix, aspirin)

Immunologic

- ❏ History of cancer
  - ❏ History of chemotherapy
  - ❏ History of radiation therapy
- ❏ HIV/AIDS
- ❏ Lyme Disease
- ❏ Lupus
- ❏ Sjogrens syndrom
- ❏ Rheumatoid arthritis

Musculoskeletal

- ❏ Osteoporosis/Osteopenia
- ❏ Do you take or have you ever taken bisphosphonates (e.g., Fosamax, Actonel, Zometa)
- ❏ Joint replacement
- ❏ Fibromyalgia
- ❏ Malignant hyperthermia
- ❏ TMJ / facial pain

Neurological / Psychiatric

- ❏ Migraine headache
- ❏ Stroke / TIA
- ❏ Aneurysm
- ❏ Seizures
- ❏ Fainting / dizzy spells
- ❏ Multiple sclerosis
- ❏ Parkinson's disease
- ❏ Dementia / Alzheimers disease
- ❏ Autism
- ❏ Bipolar
- ❏ Depression / Anxiety

Renal (Urinary)

- ❏ Renal failure / dialysis
- ❏ Kidney stones
- ❏ Other

Respiratory

- ❏ Asthma
- ❏ Chronic bronchitis
- ❏ Emphysema
- ❏ Tuberculosis
- ❏ Chronic sinusitis
- ❏ Seasonal allergies
- ❏ Sleep apnea / excessive snoring

Vision

- ❏ Glaucoma
- ❏ Wear contact lenses

Women only

- ❏ Pregnant
- ❏ Last menstrual period / /
- ❏ Breast feeding
- ❏ Birth control pills

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Past Surgical History/Hospitalizations

Please list any past surgeries or hospitalizations and dates:

Medications

Please list any medications you are taking (to also include over the counter and herbals):

Allergies

Please list any medication allergies and the type of reaction:

Miscellaneous

- ❑ Latex allergy
- ❑ History of adverse reaction to general anesthesia/sedation
- ❑ History of adverse reaction to local anesthetics

Social History

- ❑ Smoke cigarettes/cigars packs/day
- ❑ Smokeless tobacco
- ❑ Alcohol use
  - ❑ Daily
  - ❑ Weekends/Social
  - ❑ Rare
- ❑ Illicit drug use (i.e., IV drugs, cocaine, marijuana, narcotics)

Other Medical Conditions Not Listed Above

Please list any other medical conditions:

Is there anything you would like to discuss privately with the doctor? ❍ Yes ❍ No

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- To Your Family and Friends: 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. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/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 healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

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We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 3, 2017, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S. Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

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Authorization

I hereby authorize payment directly to Bluhm, Dorsch, and Vandervort, P.C. of the group insurance benefits otherwise payable to me. I authorize the use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Bluhm, Dorsch and Vandervort, P. C. to act as my agent in helping me to obtain payment from my insurance companies. I permit a copy of this authorization to be used in place of the original. I give Bluhm, Dorsch and Vandervort, P. C., its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of appointments, treatment, insurance, or payment.
I confirm that all information on this patient registration form is correct to the best of my knowledge.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /	Driver's Licence State & #:

HIPAA Patient Consent Form

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 of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Bluhm, Dorsch, and Vandervort, P.C. to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental 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 personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
If signing on behalf of someone, explain your relationship to the patient:	

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:
Describe your good faith effort to obtain the individual's signature on this form:

Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: / /