The ORAL & IMPLANT Surgery Center

PATIENT INFORMATION

Name _____ DATE OF BIRTH_____AGE_____ GENDER: Male/ Female

Home Address _____City _____ State _____ Zip_____

Home Phone _____Cell Phone _____Work Phone_____

HEALTH QUESTIONNAIRE

Patient's Physicians Name _____ Patient's Dentists Name _____

Whom shall we thank for referring you to us? _____

Have you been a patient in the hospital in the last 2 years? Yes € No €

If so, what for? _____

If you have been treated by a specialist please provide name (cardiologist, pulmonologist, etc)_____

Height:_____Weight:_____Please describe your current health:Excellent Good Fair Poor

Please describe the symptoms you are currently having (required): _____

1. Any previous surgeries? Yes € No €
2. Are you allergic to any medications or foods? Yes € No € Please list _____
   Latex allergy? YES NO
3. Are you presently taking any medications? Yes € No Please list _____
4. Female: Are you pregnant now? Yes € No €
5. Do you wear contact lens? Yes € No €
6. Do you smoke or use chewing tobacco? Yes € No €
7. Have you had anything to eat or drink in the last 6 hours? Yes € No €
8. Have you ever had jaw joint clicking, popping or TMJ problems? Yes € No €
9. Have you ever had any of the following?

Asthma	Yes €	No €	Prolonged bleeding	Yes €	No €
Heart Disease	Yes €	No €	Immune Deficiency	Yes €	No €
Heart Murmur	Yes €	No €	Hepatitis	Yes €	No €
Rheumatic Fever	Yes €	No €	High Blood Pressure	Yes €	No €
Diabetes	Yes €	No €	Epilepsy	Yes €	No €
Arthritis	Yes €	No €	Blood Disorder	Yes €	No €
HIV	Yes €	No €	Stroke	Yes €	No €
Stomach Ulcers	Yes €	No €	Kidney Disease	Yes €	No
Radiation Therapy	Yes	No	Chemotherapy	Yes	No€

10. Are you currently or have you ever taken a bisphosphonate (drug for treatment of bone loss)? Yes € No
    If so, how long and when did you take it? _____ Prescribing physician_____
11. Do you have any prosthetic joints or implanted devices? Yes € No €
    If yes, please list with dates placed. _____
12. Have you had any other serious illness, condition or problem not listed above that you think the doctor should know about?
    Yes € No €
    If yes, please list _____
13. Name and relationship of person driving you home _____

******Reminder that if you are being sedated your driver and/or vehicle that you will be traveling with/in may not leave at all******

I understand the importance of a truthful Health History and certify that the above information is true to the best of my knowledge.

_____

Date Signature of Person Completing Health History Doctor's Initials

Revised Sept 2017

PATIENT Information

Name _____ Social Security # _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone: Home (___)_____ Work: (___)_____ Cell (___)_____

Emergency Contact Name _____ Relationship _____ Phone (___)_____

IF UNDER THE AGE OF 18 OR A FULL TIME STUDENT, PLEASE COMPLETE THE FOLLOWING

Mother's Name _____ Social Security # _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone: Home (___)_____ Work: (___)_____ Cell (___)_____

Father's Name _____ Social Security # _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone: Home (___)_____ Work: (___)_____ Cell (___)_____

PRIMARY MEDICAL INSURANCE

Insurance Company:_____

Name of Policyholder: _____

Date of birth: _____SS#_____

Policy #: _____Group #:_____

Employer:_____

Relationship to patient: Self Spouse Parent Other

SECONDARY MEDICAL INSURANCE

Insurance Company:_____

Name of Policyholder: _____

Date of birth: _____SS#_____

Policy #: _____Group #:_____

Employer:_____

Relationship to patient: Self Spouse Parent Other

PRIMARY DENTAL INSURANCE

Insurance Company:_____

Name of Policyholder: _____

Date of birth: _____SS#_____

Policy #: _____Group #:_____

Employer:_____

Relationship to patient: Self Spouse Parent Other

SECONDARY DENTAL INSURANCE

Insurance Company:_____

Name of Policyholder: _____

Date of birth: _____SS#_____

Policy #: _____Group #:_____

Employer:_____

Relationship to patient: Self Spouse Parent Other

METHOD OF PAYMENT TODAY

Cash Arkansas checks only Credit/Debit Card Care Credit

***** Cardholder/account holder must be present will need to provide proof of ID*****

IF YOU ARE BEING SEDATED FOR YOUR SURGERY PLEASE LEAVE YOUR FORM OF PAYMENT & ID WITH THE PERSON THAT WILL BE TRANSPORTING YOU HOME

CONSENT FOR SERVICES

As a condition of treatment in this office financial arrangements must be made in advance. I understand that even though I have some insurance coverage I am responsible for payment of services. Any statement of benefits quoted by this office is only an **estimate of benefits** based on the information provided by your insurance company upon verification of coverage.

I authorize release of information to my insurance company and referring dentist/physician. I hereby authorize my insurance company to release payment directly to Bryan Darling DDS, MD, PA. This office will be happy to file the claim, assist in collection of that claim and explanation of how this claim was paid based on the explanation of benefits provided by your insurance company.

I have read the above conditions of payment and agree to the content.

_____ _____ _____

Signature of patient; parent, guardian/guarantor/responsible party Relationship Date

Revised Sept. 2017

COVID-19 PANDEMIC-PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose us to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	YES	NO
DO YOU HAVE A FEVER OR ABOVE NORMAL TEMPERTURE?		
HAVE YOU EXPERIENCED SHORTNESS OF BREATH OR HAD TROUBLE BREATHING?		
DO YOU HAVE A DRY COUGH?		
DO YOU HAVE A RUNNY NOSE?		
DO YOU HAVE A SORE THROAT?		
HAVE YOU RECENTLY LOST OR HAD A REDUCTION IN YOUR SENSE OF SMELL?		
HAVE YOU BEEN IN CONTACT WITH SOMEONE WHO HAS TESTED POSITIVE FOR COVID-19?		
HAVE YOU TESTED POSTIVE FOR COVID 19? IF YES DATE:		
HAVE YOU BEEN TESTED FOR COVID-19 AND ARE AWAITING RESULTS?		
HAVE YOU TRAVELED OUTSIDE THE US BY AIR OR CRUSIE SHIP IN THE PAST 14 DAYS?		
HAVE YOU TRAVELED WITHIN THE US BY AIR, BUS OR TRAIN WITHIN THE PAST 14 DAYS?		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____ _____

PATIENT NAME legal guardian date

FOLLOW-UP APPOINTMENTS

_____ _____

Legal guardian date

_____ _____

Legal guardian date

REVISED 2.26.2021

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infections during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting COVID-19 virus in the dental office or with dental treatment I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside the office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

PRINT PATIENT NAME DATE

_____ _____

SIGNATURE OF PATIENT **OR** LEGAL GUARDIAN WITNESS

BRYAN DARLING, DDS, MD, PA
D/B/A THE ORAL & IMPLANT SURGERY CENTER

Notice of Privacy Practices for Protected Health Information

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

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. 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, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office administrator at 317 Southwest Drive, Suite A, Jonesboro, AR 72401, in person or in writing, during normal office hours. She will be happy to provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office administrator at 870-933-1221. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our office. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is:

Office for Civil Rights, DHHS
1301 Young Street * Suite 1169
Dallas, TX 75202
email address – OCRPrivacy@hhs.gov

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

BRYAN DARLING, DDS, MD, PA
D/B/A THE ORAL & IMPLANT SURGERY CENTER

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

PATIENT PRINTED NAME_____

PARENT OR LEGAL GUARDIAN PRINTED NAME IF APPLICABLE_____

SIGNATURE OF PATIENT AND/ OR PARENT AND/OR LEGAL GUARDIAN_____

DATE:_____

Agreement to Receive Electronic Communication

I agree that the practice may communicate with me electronically at the email address below.

I also give my permission for the practice to communicate with my medical/dental health care providers and insurance carriers via email communication when and if necessary for the purpose of treatment, payment or operation.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: 870-933-1221
[practice's telephone number].

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient and/or Legal Guardian Signature:_____

DATE:_____

Revised October 2017