FOUR CORNERS ORAL & MAXILLOFACIAL SURGERY

NEW PATIENT INFORMATION FORM

Name _____ Date _____

First Middle Last

Address _____ City _____ State _____ Zip

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If College student, F/T P/T, name of school _____ City _____ State _____

Patient or Parent's employer _____ Work Phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or Parent's name _____ Employer _____ Work Phone _____

Whom may we thank for referring you _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Soc. Security # _____

Employer _____ Work Phone _____

Is this person currently a patient in our office ☐ yes ☐ no

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date Employed _____

Name of employer _____ Work Phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ **I.D. #** _____

Ins. Co. address _____ City _____ State _____ Zip _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

Do you have additional Insurance ☐ yes ☐ no If yes, complete the following:

Name of Insured _____ Soc. Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ **I.D. #** _____

X _____ _____

Signature of Patient (or parent, if minor) **Patient Number**

Four Corners Oral and Maxillofacial Surgery, PC

Michael W. Johnson, M.D., D.D.S.

Health Questionnaire

Name: _____ Social Security #: _____

Age: _____ Sex: _____ Weight: _____ Date of Birth: _____

Medical Doctor: _____ Referring Dentist: _____

Please answer all questions by circling yes (Y) or or no (N). All responses will be 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 physical exam: _____
4. Are you now under a physicians care for a particular problem? _____ Y N
   If so, what for? _____
5. Have you had any serious illnesses, operations or hospitalizations? _____ Y N
   If so, describe: _____
6. Have you had any adverse effects from dental treatment? _____ Y N
7. Do you or have you ever had:
   A. Rheumatic fever or rheumatic heart disease? _____ Y N
   B. Congenital heart disease? _____ Y N
   C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)? _____ Y N
   D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? _____ Y N
   E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder, or breakdown? _____ Y N
   F. Bleeding disorder, anemia, bleeding tendency, blood transfusion, do you bruise easily? _____ Y N
   G. Liver disease (jaundice, hepatitis)? _____ Y N
   H. Kidney disease? _____ Y N
   I. Diabetes? _____ Y N
   J. Thyroid disease (goiter)? _____ Y N
   K. Arthritis? _____ Y N
   L. Stomach ulcers or colitis? _____ Y N
   M. Glaucoma? _____ Y N
   N. Frequent or recurring mouth sores? _____ Y N
   O. Implants placed anywhere in your body (heart valve, knee,

hip)? _____ Y N

P. Radiation (x-ray) treatment for cancer? _____ Y N

Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? _____ Y N

R. Sinus or nasal problems? _____ Y N

S. Any disease, drugs, or transplant operation that has depressed your immune system? _____ Y N

T. Recurrent infections of any kind? _____ Y N

U. HIV or AIDS? _____ Y N

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

A. Tagamet? _____ Y N

B. Thyroid medications? _____ Y N

C. Antibiotics or sulfa drugs? _____ Y N

D. Anticoagulants (blood thinners)? _____ Y N

E. High blood pressure medicine? _____ Y N

F. Steroids (Cortisone, etc.)? _____ Y N

G. Tranquilizers? _____ Y N

H. Insulin, diabenese, or similar drug? _____ Y N

I. Digitalis, Inderal, Nitroglycerin, calcium channel blockers, Procardia or other heart medicine? _____ Y N

J. Aspirin or ibuprofen (Motrin, Naprosyn, etc.)? _____ Y N
How much daily? _____

K. Marijuana or other "street" drugs? _____ Y N

L. Antihistamines or decongestants (seldane)? _____ Y N

M. Are you taking any other regular medications, pills, or drugs? _____ Y N
Please list all medications: _____

_____

_____

_____

9. Are you allergic or had a bad reaction to :

A. Local anesthetic (Novacaine, etc.)? _____ Y N

B. Penicillin, Amoxicillin, Cephalosporins, or other antibiotics? _____ Y N

C. Barbiturates, sedatives, etc? _____ Y N

D. Aspirin or ibuprofen? _____ Y N

E. Codeine or other pain killers? _____ Y N

F. Latex or rubber products? _____ Y N

G. Eggs? _____ Y N

H. Other allergies or reactions? _____ Y N

If yes please list: _____

10. Do you smoke or chew tobacco? _____ Y N
    How much? _____
11. Do you use alcohol? _____ Y N
    How much? _____
12. Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders? _____ Y N
13. Women : Are you pregnant or planning pregnancy? _____ Y N
    Last Menstrual Period _____
    Are you taking birth control pills? _____ Y N
    Are you taking hormone replacements? _____ Y N
14. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? _____ Y N
15. Do you wish to talk with the doctor privately about anything? _____ Y N

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

_____

Signature of person completing health history Date: Dr.'s Initials

III. Understanding Your Health Information

Each time you visit our community health center; a record of your visit is created. This record usually contains your name and other information that may identify you, your symptoms, examination and test results, diagnoses, treatment, plan for future health care, and financial information. This record is sometimes referred to as your "medical record" or "medical chart." This record allows:

- Doctors, nurses, and other health professionals to plan your treatment:
- Our community health center to obtain payment for services we provide to you, such as from health plans, Medicaid, or you; and
- Our community health center to measure the quality of care provided to you.

As we have in the past, we are committed to keeping your health information confidential. We will not use or give others your health information without your written permission, except as stated in this Notice.

II. How We Will Use and Give Out Your Health Information

IV. Treatment, Payment, and Health Care Operations

We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our community health center. For example:

- We will give your health information to health care professionals not on our staff, such as other doctors and hospital staff, who help care for you;
- We may send a bill to your health insurance plan or to your; and
- Our community health center may use your medical record to review our performance and make sure you receive quality health care.

V. Other Uses and Disclosures Allowed or Required by Law

We may use or give out your health information for the following purposes under limited circumstances:

- To people who are involved in your care or who help pay for your care, such as your family, your close personal friends, or any other person chosen by you, to notify them of your location, general health, and to assist you in your health care (such as to pick-up medicine or help with follow-up care);
- To government agencies that oversee our community health center (such as license and certification inspectors);
- To government agencies that have the right to receive and collect health information (such as to control disease outbreaks);
- When we are ordered by a court or judge;

- To worker's compensation programs when your health problem is from a work-related injury;
- When law enforcement requests information (such as to prevent danger or injury);
- To coroners and funeral directors to allow them to carry out their duties;
- To organ donor agencies (subject to applicable laws);
- For research studies that meet all privacy law requirements (such as research to stop a disease);
- To avoid a serious threat to the health center that help us perform required tasks, such as our accountants, computer consultants, and billing companies (only if the business associate agrees in writing to keep your health information confidential as required by law); and
- For any other purpose required or allowed by law.

VI. Other Uses and Disclosures Requiring Your Written Permission

Except as stated above, we will use or give out your health information only after getting your written permission on an Authorization form. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

VII. Your Rights Regarding Your Health Information

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including the rights to:

- Request limits on uses of your health information.
- Receive confidential communications of your health information
- Inspect and copy your health information
- Request a change to your health information
- Receive a record of how we have used and given out your health information
- Obtain a copy of this Notice of Privacy Practices

VIII. Questions, Concerns, and Changes to this Notice

If you have any questions or want to talk about any of the information in this Notice of Privacy Practices, please contact Antonio Gurule, 204 Carson Avenue, Alamosa CO 81101. (719) 589-5161.

If you believe your privacy rights have been violated, you may file a complaint with our community health center or with the Secretary of the Department of Health and Human Services. To file a complaint with our community health center, contact the Clinic Manager in the clinic where you receive services. All complaints must be submitted in writing. We will not retaliate against you for filing a complaint.

We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by posting the change notice at our community health center.

Notice of Privacy Practices Signature Sheet

(Please Print)

Patient Name: _____

Phone Number: _____

Address: _____

Signature: _____

Date: _____

Please Print

Witness Name: _____

Signature: _____

Date: _____