HEALTH HISTORY FORM

Cedar Valley Oral Surgery P.C.

Patient Name _____ Date of Birth ____/____/____

Sex: Male / Female Height ____ ft ____ in Weight _____ lbs

Who is your general dentist? _____

Name and location of **preferred pharmacy**? Please include city _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Physician's Name _____ Place of Physician's Work _____

Are you under the care of any medical specialists? Yes No

If yes, please list the specialists name, medical specialty (ex: cardiology, oncology, etc.), and the place of physicians work:

_____

_____

_____

Please describe any symptoms you are having today:

_____

_____

_____

Have there been any changes in your general health in the past year? Yes No

If yes, please describe:

_____

_____

_____

Are you now under the care of a physician for a particular problem? Yes No

If yes, please explain:

_____

_____

_____

Date of last physical exam ____/____/____

Have you ever been hospitalized or had a serious illness? Yes No

If yes, please explain:

_____

_____

_____

—SEE REVERSE SIDE—

Patient's Name _____ Date of Birth ____/____/____

Have you ever had any surgeries? Yes No
If yes, what did you have surgery for and when?

_____

_____

_____

Have you ever had any serious reactions to anesthesia? Yes No
If yes, please explain:

_____

_____

_____

Have any immediate family members had any problems associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No

If yes, which anesthetic?_____ Relationship _____

PATIENT MEDICAL HISTORY (please circle "Y" for yes and "N" for no)

Do you have or have you ever had:

Heart disease (heart attack, heart murmur, coronary artery disease, chest pain, high or low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? Y / N

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? Y / N

Kidney disease or kidney failure? Y / N

Thyroid disease? Y / N

Stomach ulcers or colitis? Y / N

Clicking, popping, or pain within jaw joint and/or difficulty opening mouth? Y / N

Frequent or recurring mouth sores? Y / N

Radiation to the head or neck for cancer treatment? Y / N

Chemotherapy or transplant operation? Cancer? Y / N
If so, where_____
Last date of treatment_____

Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Y / N

Glaucoma? Y / N

Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? Y / N

Liver disease (jaundice, hepatitis A, B, or C)? Y / N

Diabetes? Y / N

Arthritis? Y / N

Significant weight gain or loss? Y / N

Seizures, convulsions, fainting or dizziness? Y / N

Sinus or nasal problems? Y / N

Osteoporosis or osteopenia? Y / N

HIV / AIDS? Y / N

Do you have any other disease, condition, or problem not listed above? Y / N
If yes, please explain:

_____

_____

_____

Patient's Name _____ Date of Birth _____/_____/_____

FAMILY MEDICAL HISTORY (please circle "Y" for yes and "N" for no)

Do you have a family history of any of the following? If yes, indicate the relationship

Diabetes?	Y / N	Relationship _____	Cancer?	Y / N	Relationship _____
Heart Disease?	Y / N	Relationship _____	Bleeding problems?	Y / N	Relationship _____
Tumors?	Y / N	Relationship _____	Lung disease?	Y / N	Relationship _____

FEMALE PATIENTS

Are you pregnant, or is there a chance you might be pregnant?	Yes	No
Are you currently breastfeeding or pumping?	Yes	No

MEDICATIONS (please list all medications below in next section and provide a medications list)

Currently taking...

Antibiotics?	Yes	No	Aspirin or drugs such as Motrin, Aleve, or Ibuprofen?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Insulin or oral-antidiabetic drugs?	Yes	No
Heart drugs?	Yes	No	High blood pressure medications?	Yes	No
Steroids (cortisone, prednisone)?	Yes	No	Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use.	Yes	No
Anti-anxiety agents, sedative-hypnotics and anti-depressants?	Yes	No	_____		
Prescription pain medication?	Yes	No	_____		
			_____		

Please list all medications you are taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, and vitamins or minerals:

_____

_____

_____

_____

_____

_____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or Ibuprofen?	Yes	No
Sedatives?	Yes	No	Antibiotics? If yes, please list name(s): _____	Yes	No
			_____		

Other drug allergies not listed above: _____

_____

—SEE REVERSE SIDE—

Patient's Name _____ Date of Birth __/__/__

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

Drug abuse?	Yes	No
Emotional disorders?	Yes	No
Alcoholism?	Yes	No

Do you use:

Alcohol?	Yes	No	How often? _____
Marijuana?	Yes	No	How often? _____
Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY

Have you ever had any adverse effects from dental treatment? Yes No

If yes, please explain:

_____

_____

_____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient (Parent or guardian if under 18 years of age) Date

_____ _____

Printed name of patient, parent, or guardian and relationship Doctor's Signature

HEALTH HISTORY UPDATE ONLY

Date	Patient Signature	Doctor's Signature
_____	_____	_____
_____	_____	_____

Cedar Valley Oral Surgery
820 Fisher Dr.
Waterloo, IA 50701
Ryan Borgwardt, D.D.S Brandon Syme, D.D.S.
Informed Consent

Printed Name_____**Date**_____

This is to certify that I, the undersigned, consent to the performing of the advised or necessary procedure and the use of anesthetic agents as indicated.
I further state that I have revealed all past medical conditions and treatments, as well as all medications previously taken or currently being taken.
I am aware that there are certain inherent and potential risks and side effects associated with my proposed treatment and in the specific instance they include, but are not limited to:

A. Post-operative discomfort and swelling that may require several days of at-home recovery.
B. Prolonged or heavy bleeding that may require additional treatment.
C. Injury or damage to adjacent teeth or fillings.
D. Postoperative infections that may require additional treatment..0
E. Stretch of the corners of the mouth that may cause cracking or bruising, and may heal slowly.
F. Restricted mouth opening during healing: sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
G. A decision to leave a small piece of root in the jaw when the tooth is removed would require extensive surgery or risk other complications.
H. Fracture of the jaw (usually only in more complicated extractions or surgery).
I. Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling, or other sensory disturbances in the chin, lip, cheek, gums, or tongue and which may persist for several weeks, months, or in rare instances, permanently.
J. Opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment.
K. Dry Socket (loss of blood clot from extractions site).
L. Allergic reactions (previously unknown) to any medications used in treatment.

It has been explained that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.
Anesthetic Risks include: discomfort, swelling, bruising, infections, prolonged numbness, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and although considered safe, does carry with it rare risks of heart irregularities, heart attack, stroke, brain damage, or even death.

YOUR OBLIGATIONS <u>IF IV SEDATION ANESTHESIA</u> IS USED:

A. Because anesthetic medication causes prolonged drowsiness, you MUST be accompanied by a responsible adult to drive you home and stay with you until you are sufficiently recovered to care for yourself. This may be up to 24 hours.
B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
C. You must have a completely empty stomach. IT IS VITAL THAT YOU HAVE NOTHING TO EAT FOR SIX HOURS PRIOR TO YOUR ANESTHETIC TO DO OTHERWISE MAY BE LIFE THREATENING. (You can have clear liquids.)
D. However, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or any medications provided by this office, using only a sip of water.

It has been explained to me, and I fully understand, that a perfect result is not or cannot be guaranteed. The frequency of occurrence of the above complications are different for each item, but infrequent for any of them. Please do not hesitate to consult with the doctor about anything you do not understand.

Signature_____

to contact our Privacy Manager. Contact information is provided at the bottom of the following page.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved In Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager.

Signature_____ **Date**_____

Cedar Valley Oral Surgery PC
820 Fisher Dr. Waterloo, Ia 50701
Phone (319)-233-8851

Notice of Privacy Practices

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

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free

Patient Registration Form

Name: First_____Last_____MI___

Date of Birth_____/_____/_____ Sex: Male_____Female_____

Address_____City_____State_____

Zip Code_____Phone Number(_____)_____-_____

Social Security #_____Email_____

Emergency Contact Name_____Phone #(_____)_____-_____

Referring and Family Dentist_____

(FOR CHILDREN 17 AND YOUNGER) LEGAL GUARDIAN/RESPONSIBLE PARTY INFORMATION

PLEASE COMPLETE THE FOLLOWING SECTION IF YOU ARE THE ONE COMPLETING THE PAPERWORK FOR THE MINOR

Name:First_____Last_____MI_____

Relationship_____

Address:(If different from above)_____

City_____State_____Zip Code_____

Date of Birth_____/_____/_____ Social Security #_____

Phone #(_____)_____-_____Email_____

RELEASE OF INFORMATION

(IF 18 AND OLDER)

*Description of information to be disclosed: I authorize the practice to disclose all of my protected health information to my designated personal representative.Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law. Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.
patient signature date Copies of signed authorizations are available upon request

Name of Personal Representatives:_____ DOB:_____

_____ DOB:_____

PAYMENT POLICY

*Payment in full is due on the day of service.
*Patients with insurance: As a courtesy we will file your insurance. It is up to you to know your insurance benefits and whether we participate in the plan. Any unpaid balance is your responsibility. We will collect expected out-of-pocket expenses on the day of service.
*Medicaid and Iowa Wellness Plans: You are liable for any balance that is determined by insurance to be your responsibility.
*Medicare patients: We do not participate with the Medicare Program. Therefore, any service that would be considered covered by medicare can not be filed by this office or by you.
*Biopsy patients: If an outside lab is used for pathology this is an additional charge by the outside lab and will be your responsibility. We will use the University of Iowa Pathology lab unless requested differently by you.
*Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy.
*I have read and understand the payment policy.

_____**Date**_____

Signature of Patient or Responsible Party

Insurance Form

PLEASE PROVIDE YOUR INSURANCE CARDS, **AND** COMPLETE IF YOU WOULD LIKE TO ADD INSURANCE TO YOUR ACCOUNT.

As a dental office, we will file your insurance . We strive to provide an estimate to the best of our knowledge. Payments will be rendered the day of the procedure. Not all services are a covered benefit in all contracts. It is your responsibility to know your benefits and whether we participate in the plan. Any unpaid balance will be your patient responsibility.

Patient Name:_____

DENTAL INSURANCE:

Primary Card Holder Name:First_____Last_____MI___

Relationship to patient_____

Date of Birth:_____/_____/_____ ID # or SS#_____

Employer_____ Ins. Company name_____

Secondary Card Holder Name:First_____Last_____MI___

Relationship to patient_____

Date of Birth_____/_____/_____ ID # or SS#_____

Employer_____ Ins. Company name_____

MEDICAL INSURANCE:

Primary Card Holder Name:First_____Last_____MI___

Relationship to patient_____

Date of Birth:_____/_____/_____ ID # or SS#_____

Employer_____ Ins. Company name_____

Secondary Card Holder Name:First_____Last_____MI___

Relationship to patient_____

Date of Birth:_____/_____/_____ ID # or SS#_____

Employer_____ Ins. Company name_____