NORTHEAST SURGICAL SPECIALISTS
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Acknowledgement of receipt of Notice of Privacy Practices for **«apname»**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's of Privacy Practice.

Please print your name

Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but is could not be obtained because:

__ The patient refused to sign.

__ Due to an emergency situation it was not possible to obtain an acknowledgement.

__ We weren't able to communicate with the patient.

__ Other (please provide specific details)

Employee Signature Date

NORTHEAST SURGICAL FINANCIAL CONTRACT

Our office is committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We must emphasize that as medical care providers, our relationship is with YOU and not your insurance company. We participate with select dental and medical insurance plans. Please check with the receptionist to see if your plan is included among them. We are NOT contracted with Medicare. We will gladly discuss our proposed treatment and answer any questions relating to your insurance to the best of our ability. You must realize, however, that:

Your insurance is a contract between you, your employer and your insurance company. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Insurance companies rarely reimburse the full amount of oral surgical procedures. Generally they pay between 50% and 80% of the cost. This office quotes current fees that are within the usual and customary range of oral and maxillofacial surgery practices in our area. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. Our filing the claim on your behalf does not guarantee payment nor does a pre-determination of benefits represent a guarantee of payment. We ask that a partial payment approximating your estimated percentage of the fee be made at the time of surgery. Any charges not included in the payment received from your insurance company are your responsibility. All balances unpaid by patient will be subject to a 1.5 % fee.

Please realize that if a surgical procedure is required, we bill your insurance company for our surgeon's fees only. Any services rendered outside of our office (i.e., anesthesia, pathology, labs, etc.) will be billed separately by each facility. We deal with many outside facilities, therefore, we cannot guarantee that any outside facility participates with your insurance or that all costs will be covered under your contract.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to HELP YOU.

Signature: _____ Date: _____

Welcome to Our Practice

PLEASE PRINT

Patient Information:

Referred by: «apreferral»

Name: «apfname» «apmi» «aplname» Soc. Sec.#: «apssno»
(First Name) (Initial) (Last Name)

Home Phone #: «aphphone»
Work Phone #: «apwphone»
Cell Phone #. _____

Address: «apaddrs1» **«apcity»** **«apstate»** **«apzip»**
(Street) (City) (State) (Zip)

Sex: Male - Female Age:«apage»____ Birthdate:«apdob» _____ Single-Married-Separated-Divorced-Widowed

Patient Email Address:_____ Occupation: _____
Patient Employed By:_____

If patient is a Full-time Student, Name of School/College:_____
School/College Address:_____
(Street) (City) (State) (Zip)

In case of emergency, please notify?_____Phone#:(_____)_____

Is this visit due to an accident? Yes-No If yes, Date of Accident:_____ Work related? Yes-No
Motor Vehicle? Yes-No

Please describe accident:_____

Insurance Information: Please give insurance cards to the receptionist.

Dental Insurance Carrier:_____ Group #:_____
Address: _____ ID #:_____
Insured Member's Name:_____ Birthdate:_____
Insured Member's Address:_____ Phone _____
Employed By:_____ Phone _____
Employer Address:_____
What is the patient's relationship to insured member? Self – Spouse – Child – Other
Primary Dentist Name/Address:_____ Phone _____
Does your dental insurance require a referral or prior authorization? Yes – No
If yes, have you contacted your primary dentist for a referral? Yes - No

Medical Insurance Carrier:_____ Group :_____
Address:_____ ID _____
Insured Member's Name:_____ Birthdate:_____
Insured Member's Address:_____ Phone #:_____
Employed by: _____ _____ Phone #:_____
Employer Address: _____
What is the patient's relationship to insured member? Self – Spouse – Child – Other
Primary Care Physician's Name/Address:_____ Phone #:_____
Does your medical insurance require a referral or prior authorization? Yes - No
If yes, have you contacted your primary physician for a referral? Yes - No

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to,, Northeast Surgical Specialists, otherwise payable to me. I authorize the provider/s to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance and that preauthorization of benefits does not guarantee payment. I authorize the use of this signature on all insurance submissions. I agree that I am responsible for all fees incurred if my account is turned over to a third party collector.

Patient or Responsible Parent's Signature:_____ Date_____

***If Parent Signing is different from Insured Member:** Soc. Sec.#: _____ Birthdate: _____
Address:_____
Home Phone#:_____ Work Phone #:_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name: **«apfname» «aplname»**

Patient's Date of Birth: **«apdob»** Patient's SSN: **«apssno»**

A. Person(s) or Organization(s) authorized to provide the information:

Northeast Surgical Specialist, PLLC and their Representatives

B. Person(s) or Organization(s) authorized to receive the information:

_____

_____

C. Specific description of the information that may be used or disclosed (including date(s))

_____All Health Information

_____All Financial and Insurance Information

_____Other (Please Describe)_____

D. Specific description of how the information will be used:

_____

_____

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1) I understand that this authorization will **expire** on_____.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Northeast Surgical Specialist, PLLC in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

NOTE:

You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").*

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*

You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

NORTHEAST SURGICAL SPECIALISTS
MEDICAL HISTORY FORM

Name: **«apname»** Date:_____

Date of Birth: **«apdob»** Sex: M / F Height:_____Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Why are you here today, (your chief complaint) please be specific: _____
   _____
2. Has there been any change in your health in the past year?.....Yes No
3. My last physical exam was on _____/_____/_____
4. The name of my physician is:_____
5. Please list all hospitalizations, surgeries and / or serious illness… (with appropriate dates):
   _____
   _____
   _____
6. Have you had an artificial joint replacement (knee, hip, shoulder, etc.) ……...Yes No
7. Are you taking or have you ever taken any Bisphosphonates, oral or IV, for osteoporosis or chemotherapy for multiple myeloma or metastatic cancer (These meds include: Reclast, Fosamax, Actonel, Boniva, Aredia, or Zometa)?.....Yes No
8. Please list all medication(s) including aspirin (dose), diet pills, non-prescription, vitamins, inhalers, homeopathic or natural remedies that you take currently:
   _____
   _____
9. Any medications that "thin" your blood? Please circle those that apply:
   Plavix, 81mg aspirin, 325mg aspirin, Coumadin, Lovenox, Dipyramidole
10. Have you ever required an antibiotic prior to dental procedures?.....Yes No
    If so, why? _____
11. Do you have or have you had any of the following diseases or problems?
    Circle those that apply:
    a. Damaged heart valves, artificial heart valves or heart murmur.....Yes No
    b. Rheumatic Heart Disease.....Yes No
    c. Heart trouble, high blood pressure, arteriosclerosis or any other heart condition such as palpitations, irregular heart beat or congestive heart failure? .....Yes No
       1. Chest pain upon exertion? (angina) .....Yes No
          Is this new?..... Yes No Do you experience this at rest?..... Yes No
       2. Shortness of breath after mild exercise?.....Yes No
       3. Any recent changes to your medication for your heart condition?.....Yes No
       4. Have you ever had stents placed? (When?) .....Yes No
       5. Have you ever had bypass surgery? (When?).....Yes No
       6. Have you ever had a heart attack? (When?).....Yes No
    d. Seasonal allergies/ hay fever .....Yes No
    e. Sinus trouble .....Yes No
    f. Asthma..... .....Yes No
       1. Have you ever been hospitalized for your asthma? .....Yes No
       2. What triggers your asthma?_____
    g. Diabetes .....Yes No
       If yes, what type: I or II How long ago were you diagnosed? _____

h. Hepatitis A, B, or C or other liver dysfunction diseases? ..... Yes No
i. Thyroid problems ..... Yes No
j. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
k. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
l. History of sleep apnea ..... Yes No
If yes, do you use a CPAP machine?.. Yes No Other treatments: _____
m. Stomach or GI ulcers ..... Yes No
n. Reflux disease (GERD) ..... Yes No
o. Kidney trouble ..... Yes No
p. Tuberculosis ..... Yes No
q. Persistent cough or cough that produces blood ..... Yes No
r. History of CVA or stroke ..... Yes No
s. History of TIA's (ministrokes) ..... Yes No
t. Epilepsy or neurological disorder ..... Yes No
u. Cancer ..... Yes No
If yes, what type:_____
1. What was the treatment:_____
2. Have you ever had other tumors or growths in the head neck region? ..... Yes No
3. Treated or removed?... Yes No
4. Have you ever had radiation therapy to the head, neck, or jaw? ..... Yes No
5. If so, who is your radiation oncologist? _____
v. Any diseases, including HIV, drug or transplant operation that has depressed your immune system ..... Yes No

_____

12. Have you ever had abnormal bleeding? ..... Yes No
13. Do you have a family history of abnormal bleeding (Vonwillebrand Disease, hemophilia) ... Yes No
14. Do you have any blood disorder such as anemia? ..... Yes No
15. Are you allergic to or have you had a reaction to:

Local anesthetics	Yes	No	Reaction:	
Penicillin or antibiotics	Yes	No	Reaction:	
Sulfa drugs	Yes	No	Reaction:	
Barbiturates or sleeping pills	Yes	No	Reaction:	
Aspirin	Yes	No	Reaction:	
Iodine	Yes	No	Reaction:	
Codeine or other narcotics	Yes	No	Reaction:	
Latex or rubber products	Yes	No	Reaction:	
Eggs	Yes	No	Reaction:	
Soy	Yes	No	Reaction:	
Avocados	Yes	No	Reaction:	
Bananas	Yes	No	Reaction:	
Kiwi	Yes	No	Reaction:	
Other:	Yes	No	Reaction:	
Other:	Yes	No	Reaction:	
Other:	Yes	No	Reaction:	

Please note avocados, bananas, and kiwi may indicate potential for a latex allergy

16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
If so, explain:_____

_____

17. Do you have any other condition or disease you think the doctor should know about? .....Yes No
    If so, explain:_____
18. Do you smoke or chew Tobacco? .....Yes No
    How much? _____ For how long? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder
    that may affect the care we provide you?.....Yes No
20. Do you wish to talk with the doctor privately about anything? .....Yes No
    .....No

Women

Are you pregnant or trying to become pregnant.....Yes No
Do you experience excess bleeding with your menstrual period?.....Yes No
Are you nursing?.....Yes No
Are you taking birth control pills? .....Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date:_____Patient's Signature:_____

Date:_____ Pulse:_____ B/P:_____ O_2:_____%

Medical History Update:

Date Update
_____ _____
_____
_____
_____

Date Update
_____ _____
_____
_____
_____

Date Update
_____ _____
_____
_____
_____

Date Update
_____ _____
_____
_____
_____

NORTHEAST SURGICAL SPECIALISTS

Medical History Update

Patient Name: _____ **Birthdate:** _____

Please review your medical history form and note any changes or updates that need to be made. If your most recent history form is more than three years old we require a new form to be filled out.

I have reviewed the attached Medical History Form. My (or the patient's) health and medications have changed as follows (if no change, write "No Change"):

_____
_____
_____

Signature: _____ Date: _____

Update Reviewed by Dr. _____

I have reviewed the attached Medical History Form. My (or the patient's) health and medications have changed as follows (if no change, write "No Change"):

_____
_____
_____

Signature:_____ Date: _____

Update Reviewed by Dr. _____

I have reviewed the attached Medical History Form. My (or the patient's) health and medications have changed as follows (if no change, write "No Change"):

_____
_____
_____

Signature:_____ Date: _____

Update Reviewed by Dr. _____

NORTHEAST SURGICAL SPECIALISTS

Anesthesia evaluation:

Name_____ Date_____

Any personal history or family history of prior anesthetic reactions or difficulties?_____

_____

Physical Exam General Appearance: _____

_____

Head and Neck:

Neck	Short	Yes/ No	_____
	Thick	Yes/ No	_____
	Masses	Yes/ No	_____
	Scars	Yes/ No	_____
	Limited ROM	Yes/ No	_____

Intraoral:

Soft palate redundant	Yes/ No	_____
Limited oral opening	Yes/ No	_____
Large tongue	Yes/ No	_____
Prosthesis	Yes/ No	_____
Loose teeth	Yes/ No	_____
Malampati Class	I II III	

CV:

HR RRR	Yes/ No	_____
Murmur	Yes/ No	_____

Lungs:

RR observed normal	Yes/ No _____
Ausculation	rales/ rhonchi/ wheezing/ CTA B

Neurologic:

CN intact	Yes/No _____
Gait disturbance	Yes/No _____
Weakness of extremities	Yes/ No_____
Garbled speech	Yes/ No _____

Ext: Peripheral swelling Yes/ No _____

Other:_____

Smoker: Yes/ No _____ packs per day _____ years

ASA Class I II III

Lab Info: Yes/ No _____

Assessment: Yes/ No - Acceptable candidate for IV anesthesia

Anes. Plan: IV Sedation_____

IVGA_____

Other_____

NPO/Escort_____