Douglas M. Reid DMD, MD
OralSurgeryDurango.com

PATIENT INFORMATION

Patient Name: _____ Sex: Male ○ Female ○

Date of Birth: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Guarantor/Family Email: _____

Employer: _____ Employer Address: _____

Marital Status: Single ○ Married ○ Divorced ○ Widowed ○ Decline ○

Spouse Name: _____ Spouse DOB: _____ Spouse SSN: _____

Is your condition a result of a work injury? Yes ○ No ○ Auto Accident? Yes ○ No ○ Date: _____

Preferred Pharmacy: _____

RESPONSIBLE PARTY

☐ **Check if the same as patient information**

Person Responsible for Payment: _____ Date of Birth: _____

Relationship to Patient: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Employer Phone: _____

Spouse Name: _____ Spouse DOB: _____ Spouse SSN: _____

REFERRAL INFORMATION

Referring Dentist: _____

Primary Care Physician: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION (Do not complete if insurance card is present)

Insurance Coverage: Yes ○ No ○ If no, how do you intend to pay? ☐ Cash ☐ Check ☐ Credit Card

Primary Insurance: _____ ID Number: _____ Group: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Insurance: _____ ID Number: _____ Group: _____

Policy Holder Name: _____ Policy Holder DOB: _____

FINANCIAL POLICY ACKNOWLEDGEMENT AND AGREEMENT

Payment is required at the time of service. This includes all co-payments and self-pay fees. You will also be responsible for any coinsurance, deductibles, and non-covered services. We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage; your insurance policy is a contract between you and your insurance company. We cannot guarantee payment or coverage of your claim.

If we are able to accept your insurance company's assignment, the patient is still fully responsible for the charges for treatment rendered. Your insurance may not cover the services or may only partially cover them and any estimate given by this office is considered a guideline until the final insurance is received and the patient's account is reconciled. The office can make no guarantee of the actual payment by your insurance company. For services that have been predetermined, the amount the insurance company may pay may be subject to maximums, deductibles, limitations, and non-payment due to employment status.

While we make every available effort to assist you, understanding the details of your coverage is your responsibility. In most cases, we are not a party to this contract. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If we are not a provider under your insurance plan, you will be responsible for payment in full at the time of service. As a courtesy, however, we will file your initial insurance claim and the assignment of benefits will be sent to you from your insurance company.

We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit. Our office will accept cash, personal checks, Visa, MasterCard, Discover and American Express credit cards. You are ultimately responsible for all clinic and surgery fees relating to your care.

I agree to pay all fees and charges for services rendered at Oral Surgery Durango for myself and/or my family. Responsible party agrees to pay all charges when presented with a statement, unless prior credit arrangements are agreed upon in writing. I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balance on the stated account.

Per our office policy, accounts that reach 90 days past due are subject to a 30% collections fee and may be referred to a collection agency. To avoid this additional charge, please contact our office as soon as possible to arrange payment.

Minors: If the patient is age seventeen or younger they are a minor. A parent or guardian must accompany the patient for treatment. We realize that many families are in a state of change. Divorced, separated, single parent and blended families are now common. In many of these families the question of who is responsible for the children's account is uncertain. The policy in our office is that the parent who requests treatment for the child is responsible for all fees incurred. Settlement must be resolved between the parents.

Patients with guardians: A patient who cannot consent to treatment has a legal guardian. Our office will need complete health history prior to the day of any treatment. A guardian must be available to discuss patient care and treatment with the doctor.

I have read and understand the Financial Policy for Oral Surgery Durango.

Patient Name:_____

Patient/Guardians Signature: _____ Date:_____

I authorize the following individual to access my medical information, including all billing and/or insurance transactions

Name: _____ Relationship: _____

CANCELLATION/RESCHEDULE ACKNOWLEDGEMENT AND AGREEMENT

Our goal at Oral Surgery Durango is to provide quality dental care in a timely manner. We are committed to delivering your care in the most considerate and professional manner. The following is a statement of our Cancellation and Reschedule Policy, which we require you to read and sign before any evaluation or treatment.

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 48 hours before your scheduled appointment time. You may do so by calling 970-449-0824.

If you do not show up for your appointment, cancel or reschedule within 48 hours of your appointment time, we will consider that a no-show. No-show appointments may be subject to a $150 rescheduling fee. No-show fees are the patient's sole responsibility and must be paid in full before your next appointment. If the no-show fee might prevent you from receiving necessary care, please contact us.

We do understand that emergencies happen (i.e., illness, weather, accidents) but we ask for at least 48 hours' notice to reschedule an appointment if needed, so that we may assist other patients. We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice management's sole discretion.

*After two (2) failed appointments we will require a deposit of 100% that will be applied to your appointment, in order to reserve any further appointments. This deposit will be non-refundable if you cancel with less than 48 hours or no call no show the appointment.

*After three (3) failed appointments you risk being dismissed from the practice.

I have read and understand the Cancellation/Reschedule Acknowledgement and Agreement for Oral Surgery Durango.

Patient Name: _____

Patient/Guardians Signature: _____ Date: _____

HEALTH HISTORY FORM

An accurate and complete health history will assist in coordinating your dental care.
Please speak with the doctor or staff if there are any questions about this form.

Patient Name: _____ Date of Birth: _____

Gender: _____ Height: _____ Weight: _____ Today's Date: _____

FEMALE PATIENTS

Are you pregnant? Yes ◯ No ◯ Is there any chance you might be pregnant? Yes ◯ No ◯

DENTAL HISTORY

Please describe your current dental health: Excellent ◯ Good ◯ Fair ◯ Poor ◯
Please describe why you are in the office today: _____

Have there been any changes in your dental health in the past year? Yes ◯ No ◯
If yes, please describe: _____

Are you currently having any dental discomfort? Yes ◯ No ◯
If yes, please describe: _____

Have you had any adverse effects from dental treatment? Yes ◯ No ◯
If yes, please describe: _____

Date of last dental visit? _____

Dental—Do you have or have you ever had any of the following:

Bleeding / Sore Gums?	Yes ◯	No ◯	Shifting in Bite?	Yes ◯	No ◯
Unpleasant Taste / Bad Breath?	Yes ◯	No ◯	Change in Bite?	Yes ◯	No ◯
Swelling / Lumps in Mouth?	Yes ◯	No ◯	Burning Tongue or Lips?	Yes ◯	No ◯
Orthodontic Treatment (Braces)?	Yes ◯	No ◯	Frequent Blisters, Lips or Mouth?	Yes ◯	No ◯
Clenching / Grinding?	Yes ◯	No ◯	Sensitive Teeth—Hot or Cold)?	Yes ◯	No ◯
Sensitive to Sweets?	Yes ◯	No ◯	Clicking / Popping Jaw?	Yes ◯	No ◯
Sensitive to Biting?	Yes ◯	No ◯	Difficulty Opening or Closing Jaw?	Yes ◯	No ◯
Food Impaction?	Yes ◯	No ◯	Loose Teeth?	Yes ◯	No ◯
Biting Cheeks or Lips?	Yes ◯	No ◯			

MEDICAL HISTORY

Please describe your current overall health: Excellent ◯ Good ◯ Fair ◯ Poor ◯

Name of Physician: _____ Physician's Phone Number: _____

Have there been any changes in your general health in the past year? Yes ◯ No ◯
If yes, please describe: _____

Are you now under a doctor's care for a medical condition? Yes ◯ No ◯ Date of last physical exam? _____
If yes, please describe: _____

Name of Physician: _____ Physician's Phone Number: _____

Have you ever been hospitalized or had a serious illness? Yes ◯ No ◯
If yes, please describe: _____

Have you ever had surgery? Yes ◯ No ◯
If yes, please describe: _____

MEDICAL—Do you have or have you ever had any of the following conditions:

Heart Attack?	Yes ◯ No ◯	Kidney Disease / Failure—Requiring Dialysis?	Yes ◯ No ◯
Heart Murmur?	Yes ◯ No ◯	Liver Disease—Hepatitis B or C or Jaundice?	Yes ◯ No ◯
Coronary Artery Disease?	Yes ◯ No ◯	Thyroid Disease?	Yes ◯ No ◯
Angina / Chest Pain?	Yes ◯ No ◯	Stomach Ulcers or Colitis?	Yes ◯ No ◯
High Blood Pressure?	Yes ◯ No ◯	Diabetes?	Yes ◯ No ◯
Stroke?	Yes ◯ No ◯	Glaucoma?	Yes ◯ No ◯
Irregular heartbeat?	Yes ◯ No ◯	Tuberculosis?	Yes ◯ No ◯
Heart surgery?	Yes ◯ No ◯	Arthritis?	Yes ◯ No ◯
Pacemaker?	Yes ◯ No ◯	Anemia?	Yes ◯ No ◯
Asthma?	Yes ◯ No ◯	Bleeding Tendency or Easily Bruise?	Yes ◯ No ◯
Emphysema?	Yes ◯ No ◯	Blood Transfusion?	Yes ◯ No ◯
COPD?	Yes ◯ No ◯	Significant Weight Loss or Gain?	Yes ◯ No ◯
Chronic Coughing?	Yes ◯ No ◯	Sinus or Nasal Problems?	Yes ◯ No ◯
Bronchitis?	Yes ◯ No ◯	Sleep Apnea?	Yes ◯ No ◯
Pneumonia?	Yes ◯ No ◯	Osteoporosis?	Yes ◯ No ◯

Cancer? Yes ◯ No ◯ If yes, type: _____ Diagnosis Date: _____
Treatments: _____

Implants Placed Anywhere in the Body–Heart Valve, Pacemaker, Hip / Knee? Yes ◯ No ◯

If Yes, Type: _____ Surgery Date: _____ Do you Pre-medicate? Yes ◯ No ◯

Do you have any other medical conditions that are important for your doctor to know about? Yes ◯ No ◯

If yes, please describe: _____

FAMILY MEDICAL HISTORY – Do you have a family history of any of the following conditions?

Diabetes?	Yes ◯ No ◯	Relationship: _____
Lung Disease?	Yes ◯ No ◯	Relationship: _____
Cancer?	Yes ◯ No ◯	Relationship: _____
Heart Disease?	Yes ◯ No ◯	Relationship: _____
Bleeding Problems?	Yes ◯ No ◯	Relationship: _____

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes ◯ No ◯

If yes, please describe: _____

MEDICATIONS—Are you currently prescribed or taking any of the following?

Antibiotics?	Yes ◯ No ◯	Medication / Dose: _____
Anticoagulant / Blood Thinners?	Yes ◯ No ◯	Medication / Dose: _____
Heart Medications?	Yes ◯ No ◯	Medication / Dose: _____
Steroids?	Yes ◯ No ◯	Medication / Dose: _____
Anti-anxiety / Anti-depressants / Psychiatric Medications?	Yes ◯ No ◯	Medication / Dose: _____
Cancer / Chemotherapy Drugs?	Yes ◯ No ◯	Medication / Dose: _____
Prescription Pain Medications?	Yes ◯ No ◯	Medication / Dose: _____
Aspirin / Naproxen / Ibuprofen?	Yes ◯ No ◯	Medication / Dose: _____
Insulin / Oral Anti-Diabetic Drugs?	Yes ◯ No ◯	Medication / Dose: _____
Blood Pressure Medications?	Yes ◯ No ◯	Medication / Dose: _____
Osteoporosis Medications / Bisphosphonates?	Yes ◯ No ◯	Medication / Dose: _____

MEDICATIONS—Please list any medications not listed above that you are currently taking. Include prescription medications, diet drugs, over the counter medications, herbal/holistic remedies, vitamins or minerals:

Medication / Dose: _____	Medication / Dose: _____
Medication / Dose: _____	Medication / Dose: _____
Medication / Dose: _____	Medication / Dose: _____

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

Antibiotics?	Yes ◯ No ◯	Medication/Reaction: _____
Codeine / Other Pain Medications?	Yes ◯ No ◯	Medication/Reaction: _____
Sedatives / Barbiturates?	Yes ◯ No ◯	Medication/Reaction: _____
Food / Food Products?	Yes ◯ No ◯	Food/Reaction: _____
Aspirin / Naproxen / Ibuprofen?	Yes ◯ No ◯	Medication/Reaction: _____
Latex?	Yes ◯ No ◯	Medication/Reaction: _____
Other Allergies / Medication Allergies?	Yes ◯ No ◯	Medication/Reaction: _____

ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes ◯ No ◯

If yes, please describe: _____

SOCIAL HISTORY

Do you currently smoke, vape or chew tobacco?	Yes ◯ No ◯	If yes, for how long? _____
History of smoking, vaping or chewing tobacco?	Yes ◯ No ◯	If yes, for how long? _____
Do you use alcohol?	Yes ◯ No ◯	If yes, how often per week: _____
Do you use marijuana?	Yes ◯ No ◯	If yes, how often per week: _____
Do you use any recreational drugs?	Yes ◯ No ◯	If yes, how often per week: _____

Have you ever sought professional care or been hospitalized for:

Substance abuse?	Yes ◯ No ◯
Emotional disorders?	Yes ◯ No ◯
Alcoholism?	Yes ◯ No ◯

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes ◯ No ◯

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

_____

Printed Name of Patient

_____

Printed Name of Parent/ Guardian and Relationship to Patient

_____ _____

Signature of Patient or Parent/Guardian Date

For Office Staff Use - ADDITIONAL CLINICAL DOCUMENTATION

_____

_____

_____

_____

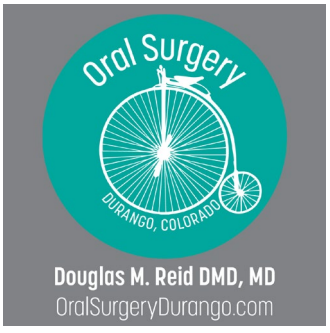
_____

_____

_____

_____

_____



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Available upon request or online

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I hereby certify that I am aware of, I have reviewed, or I have received a copy of the Notice of Privacy Practices for the following office:

Oral Surgery Durango
575 Rivergate Lane #98
Durango, CO 81301
970-449-0824

_____
Printed Name of Recipient

_____ _____
Signature Date

For Office Use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the above referenced individual, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgment

____ An emergency prevented us from obtaining acknowledgment

____ Other

Douglas M. Reid DMD, MD

Notice of Privacy Practices for Protected Health Information

<u>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</u>!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations.

Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

<u>Your Health Information Rights</u>

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 us, in person or in writing, during normal hours. We will 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 us.

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 us. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- 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.