Laurence D. Popowich, D.D.S.
Robert Laski, D.M.D.
Jaime M. Cernansky, D.M.D., M.D.
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Diplomates American Board of Oral and Maxillofacial Surgery

VALLEY ORAL SURGERY P.C.

PATIENT INFORMATION RECORD

PLEASE PRINT

Date _____

BP Reading _____

Date _____

Patient Name _____ How did you hear about us? _____

Social Security# _____ Date of Birth _____ ❑ Male ❑ Female

Home Address _____

City/State/Zip Code _____ Email Address _____

Home Phone _____ Family Dentist _____
(FIRST & LAST NAME)

Cell Phone _____ Family Physician _____
(FIRST & LAST NAME)

Employed by _____ Marital Status _____

Occupation _____ Employer Phone _____

Parent/Guardian/Spouse Name _____
(FIRST & LAST NAME)

Person Responsible for this account _____

In case of emergency, please contact _____ Phone# _____

MEDICAL INSURANCE – Please complete all information

Primary Policyholder Name _____ Relationship to Patient _____

Social Security # _____ Birthdate _____

Employer _____ Business Phone # _____

Insurance Name _____

ID # _____ Group # _____

Secondary Policyholder Name _____ Relationship to Patient _____

Social Security # _____ Birthdate _____

Employer _____ Business Phone # _____

Insurance Name _____

ID # _____ Group # _____

DENTAL INSURANCE – Please complete all information

Primary Policyholder Name _____ Relationship to Patient _____

Social Security # _____ Birthdate _____

Employer _____ Business Phone # _____

Insurance Name _____

ID # _____ Group # _____

Secondary Policyholder Name _____ Relationship to Patient _____

Social Security # _____ Birthdate _____

Employer _____ Business Phone # _____

Insurance Name _____

ID # _____ Group # _____

CONTINUED ON BACK

HEALTH HISTORY

1. Are you in good health? . . . . . Y N
2. Height:_____ Weight:_____
3. Has there been any change in your general health in the past year? . . . . . Y N
   If yes, explain: _____
   _____
   _____
   _____
4. Date of last physical exam_____
5. Are you now under a physician's care for a particular problem? . . . . . Y N
   If yes, explain: _____
   _____
   _____
   _____
6. Have you ever had any serious illnesses, operations or hospitalizations? . . . . . Y N
   If so, describe:_____ year_____
   _____ year_____
   _____ year_____
   _____ year_____
   _____ year_____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**

A. Rheumatic Fever or Rheumatic Heart Disease? . . . . . Y N
B. Congenital Heart Disease? . . . . . Y N
C. Cardiovascular Disease (Heart Attack, Heart Trouble, 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 or Dizziness? . . . . . 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. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee, etc)? . . . . . Y N
O. Radiation (x-ray) treatment for Cancer? . . . . . Y N
P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? . . . . . Y N
Q. Sinus or Nasal Problems? . . . . . Y N
R. Any disease, drug or transplant operation that has depressed your immune system? . . . . . Y N

8. **ARE YOU USING ANY OF THE FOLLOWING:**

A. Antibiotics? . . . . . Y N
B. Anticoagulants (Blood Thinners)? . . . . . Y N
C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? . . . . . Y N
D. High Blood Pressure Medications? . . . . . Y N
E. Steroids (Cortisone, etc)? . . . . . Y N
F. Bisphosphonates (Fosamax)? . . . . . Y N
G. Insulin or Oral Anti-Diabetic Drugs? . . . . . Y N
H. Digitalis, Inderal, nitroglycerin or other heart drug? . . . . . Y N
I. Please list all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:
   _____ Dosage_____
   _____ Dosage_____
   _____ Dosage_____
   _____ Dosage_____

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A. Local Anesthesia (Novocaine, etc.)? . . . . . Y N
B. Penicillin or other antibiotics? . . . . . Y N
C. Sedatives, Barbiturates? . . . . . Y N
D. Aspirin or Ibuprofen? . . . . . Y N
E. Codeine or other painkillers? . . . . . Y N
F. Latex or Rubber Products? . . . . . Y N
G. Other allergies or reactions? Please list: . . . . . Y N
   _____
   _____

10. Do you smoke or chew tobacco? . . . . . Y N
    How much per day?_____
11. Is there a history of Alcohol or Chemical dependency or emotional disorder that may affect the care we provide you? . . . . . Y N
    If yes, explain: _____
    _____
    _____
12. Have you had any serious problems associated with any previous dental treatment? . . . . . Y N
    If yes, explain: _____
    _____
    _____
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? . . . . . Y N
    If yes, explain: _____
    _____
    _____
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? . . . . . Y N
    If yes, explain: _____
    _____
    _____
15. Do you wish to talk to the doctor privately about anything? . . . . . Y N
16. **FOR WOMEN ONLY**

A. Are you Pregnant, or **is there any chance** you might be Pregnant? . . . . . Y N
B. Are you nursing? . . . . . Y N
C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.
D. Bisphosphonates (Fosamax)

CHIEF DENTAL COMPLAINT:_____

_____

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.

I verify that the above information is correct and understand that the financial obligation for treatment rendered is my responsibility. I hereby authorize my insurance benefits be paid directly to the dentist and I am financially responsible for non-covered services. I also authorize the dentist to release any information required.

It is the policy of the practice not to discriminate in the delivery of health care services on the basis of race, ethnicity, national origin, sex, age, health status (to include, but not be limited to, mental or physical disability or medical condition, genetic information, claims experience, medical history, evidence of insurability, and conditions arising out of domestic violence), or sexual orientation.

Signature_____ Date _____

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VALLEY ORAL SURGERY P.C.

Leaders and Innovators in Oral Surgery since 1983

Financial Policy

Valley Oral Surgery participates with many insurance plans and will file your claim for you. Insurance varies significantly from employer to employer and from plan to plan. As a courtesy to our patients, Valley Oral Surgery will contact your insurance company to establish an estimate of benefits, deductible and/or copayments based on the proposed treatment plan. Information given to us by your insurance company is an estimate and does not guarantee coverage or payment.

Please be aware that some procedures may not be covered or considered medically necessary by your insurance carrier. At the time of your consultation, financial arrangements will be openly discussed. Please note financial obligations for the treatment rendered are the patient's responsibility.

Patients with managed care contracts may need to obtain a referral from their primary care physician.

For your convenience, we accept the following methods of payment: Cash, Check, Visa, MasterCard, American Express, Discover and Care Credit.

If you are a patient of record, please advise us promptly of any changes in your address, health status or insurance information.

Thank you for choosing Valley Oral Surgery.

_____ _____

Signature Date

Valley Oral Surgery Form Completion Policy

Valley Oral Surgery offers completion of forms as an added service to patients. We have the following policy in place as outlined below.

Instructions:

- Pre-payment of $15 per form is required.
- The following forms will be assessed a $15 fee for completion:
  - FMLA
  - Disability/Life Insurance
  - Letter of condition
  - Miscellaneous Patient Requests
- Patient must complete all of their information on the form prior to submitting to the office.
- Forms must be requested well in advance of when they are needed. We will attempt to complete the forms as quickly as possible but please allow 5-7 business days.
- Provide a stamped, addressed envelope to expedite mailing of completed forms.

By signing below I attest that I have read and understood the above. Upon request, I will be provided a copy of this document for my records.

_____

Printed Name of Patient (Patient's Representative if patient is a minor)

_____

Signature of Patient (Patient's Representative if patient is a minor)

_____

Date

VALLEY ORAL SURGERY, PC

COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

READ BEFORE SIGNING THE ACKNOWLEDGEMENT AND CONSENT

This acknowledgement of notice and consent authorizes Valley Oral Surgery to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices. Valley Oral Surgery has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

HOW TO CONTACT OUR PRIVACY OFFICER

Mail: Valley Oral Surgery
Attention: Privacy Officer
1275 S. Cedar Crest Blvd., Suite 1
Allentown, PA 18103

Telephone: 610-437-1727

Facsimile: 610-437-4715

ACKNOWLEDGEMENT AND CONSENT (PRINT OR TYPE ALL INFORMATION EXCEPT SIGNATURE)

I have received the Notice of Privacy Practices for Valley Oral Surgery and authorize them to use and disclose health information about _____(patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of patient (or patient's personal representative) Date

Personal representative information (if applicable):

_____ _____
Name of personal representative Relationship to patient (or other authority)

VALLEY ORAL SURGERY, PC

COMMUNICATION CONSENT

It is the office policy of Valley Oral Surgery, PC and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail and/or cell phone. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Valley Oral Surgery, PC and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone_____

Answering Machine _____

Work Telephone_____

Voice Mail _____

Cell Phone and/or Voice Mail_____

E-mail_____

If you would like to have information released to someone other than yourself please complete the following:

Please list names of authorized people:

_____ Relationship:_____

_____ Relationship:_____

In order for us to manage/service your account or to collect monies you may owe, Valley Oral Surgery, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone, which may result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device as applicable.

Printed Name _____

Patient/Guardian Signature:_____Date:_____

Business associates: There are some services provided in our organization through contacts with business associates. Examples include: physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, 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 payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

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

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Release Authorizations: Certain disclosures and uses of patient information require authorization from the patient.

Disclosures include:

Psychotherapy notes: These notes are from a mental health professional and are kept separate from your record.

Fundraising: The office does not use any personal information in Marketing or Fundraising.

Restricting information releases: A patient who pays for a service in full and out of pocket may request that the office not disclose any information about the service to an insurance company. The request must be in writing and has to identify what information is restricted and what insurance company is not to receive it, including Medicare and Medicaid.

Breach notifications: Patients will be notified in writing when a breach in their protected information occurs. Any loss or inappropriate disclosure of data is a breach.

Patients may ask for their records in electronic format (if available). The office must supply this information within 30 days.

NOTICE OF PRIVACY PRACTICES FOR

VALLEY ORAL SURGERY, P.C.

1275 S. Cedar Crest Blvd., Suite 1
Allentown, PA 18103
(610) 437-1727

1321 North New Street
Bethlehem, PA 18018
(610) 861-0648

5666 Interchange Rd.
Lehighton, PA 18235
(484) 629-8300

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Valley Oral Surgery, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 4/14/03 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Valley Oral Surgery, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- Tool in educating health professionals.
- Source of data for medical research.
- Source of information for public health officials charged with improving the health of this state and the nation.
- Activities conducted to obtain payment for your care.
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Valley Oral Surgery, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Valley Oral Surgery is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice in the office.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at **610-437-1727**.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.