

DRS. AKERS, STOHLE & BORDEN
ORAL, MAXILLOFACIAL AND IMPLANT SURGERY

Patient: (Mr., Mrs., Ms., Dr.,) _____ Date _____

First Name _____ M.I. _____ Last Name _____

Sex: Male Female Date of Birth: _____ Age: _____ Social Security # _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Home Phone # (____) - _____ Work # (____) - _____ Ext.# _____ Employer _____

Dentist _____ Medical Doctor _____ **REFERRED BY** _____

Marital Status: Married Single Divorced Separated Widow

Student: Full Time Part Time None School Name/Address _____

Have you ever been a patient of our practice? Yes No Method of personal payment Cash Check Credit Card

Guarantor/Insured Information (if different from above):

Name _____ Sex Male Female S.S. # _____ - _____ - _____

Home Phone # (____) - _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work # (____) - _____ Ext. # _____

Fees, Payments & Insurance

We make every effort to keep down the cost of your oral surgery care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending on special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request.

If you have dental and/or medical insurance we will fill out the appropriate forms to help you receive your maximum allowable benefits. Please be aware that your insurance is a contract between you and your insurance company. We are not a party to that contract, therefore insurance is not a substitute for payment. We will submit any necessary information to your insurance company upon your request. Your fees are your responsibility as well as any returned check fees, collection costs, attorney's fees, and/or court costs.

This signature on file acknowledges that I am the responsible party for this account and authorizes the release of information necessary to process my claim. If this account is not paid in full, I hereby authorize payment to this doctor named of the benefits otherwise payable to me. I also understand that the Office HIPAA Policy is available for my review.

Signature of Responsible Party: _____

MEDICAL HISTORY

Patient Name _____

Date _____

Yes **No**

1. Are you now, or have you been under a physician's care during the last **six years**? _____

Reason: _____

2. Are you **now** taking or **within the past six months** have you taken any medications or drugs? _____

Please Specify: _____

3. Have you ever had any operation, serious illness, or been hospitalized in the **past five years**? _____

Please Specify: _____

4. Are you **allergic** or **sensitive** to any drugs, medications, or anesthetics? _____

Please Specify: _____

5. Have you ever had any unusual shortness of breath, chest pain, dizzy spells or ankle swelling? _____

6. Have you ever had any breathing problems such as asthma, bronchitis, emphysema, or lung disease? _____

7. Do you have or have you ever had: (check if yes)

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Heart Disease or Heart Attack | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Allergies | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Angina or Chest Pain | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Asthma / Bronchitis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> Epilepsy/Seizures | |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Nervous or Mental Disorder | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Splenectomy | <input type="checkbox"/> Hip or Joint Replacement | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Contact Lenses | |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Pain and Clicking of Jaw | |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemotherapy | |

8. Do you presently have a cold, cough, fever, or sore throat? _____

9. Weight _____ Do you smoke _____

10. If you are female, is there a possibility of pregnancy? Yes No Are you nursing? _____

11. Are you taking birth control pills? _____

12. Do you have a prosthetic joint / implant? _____

Specify where: _____

13. Have you ever taken **bisphosphonates** (ie Aredia, Zometa, Fosamax, Actonel, Boniva) for osteoporosis or cancer?

14. Have you ever had a Heart Valve Replacement or Vascular Graft? _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient:

Reviewed by:

Date:

DRS. AKERS, STOHLE & BORDEN, LTD.
ORAL AND MAXILLOFACIAL SURGERY

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you may access this information.

With your consent, Drs. Akers, Stohle & Borden, Ltd. 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 use 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 a 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 the medical care given. We will provide information to them about you and the care given.

Example of use of your health 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. We will occasionally leave information on your answering machine.

Your Health Information Rights

The health record we maintain and billing records are the physical property of Drs. Akers, Stohle & Borden, Ltd. 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 will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record that are generated only by Akers, Stohle & Borden Ltd. 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 record be amended to correct or complete information by delivering a written request to our office;
- File a statement of disagreement if your amendment request is denied, and require that the amendment request 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;
- 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 Jessica S. at 500 Davis Street Suite 509, Evanston, IL 60201 in writing. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

Drs. Akers, Stohle & Borden, Ltd. 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 request;
- 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 Jessica S. at 847-869-9303.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering it to Jessica S. at the above address. You may also file a complaint by mailing it to the Secretary of Health & Human Services at U.S. Dept of Health and Human Services 200 Independence Avenue, SW Washington D.C. 20201, or visit www.hhs.gov

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health & 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.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for the health and safety of you and other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as by court order, cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Effective Date: April 14, 2003

DR.S AKERS, STOHLE & BORDEN, LTD.
ORAL AND MAXILLOFACIAL SURGERY

I, _____, hereby acknowledge that I have received a copy of Drs. Akers, Stohle & Borden, Ltd.'s Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature

Date