



Lane Oral & Maxillofacial Surgery P.C. & Dental Implant Center

WILLIAM F. LANE, D.M.D.

GLENN A. BRANCA, D.D.S

Patient Information & Medical History

Patient name: Date of Birth:

General Dentist: General Dentist Address:

Primary Care Physician: Purpose of this appointment:

- 1. Are you having pain or discomfort at this time?
2. Have you ever been asleep for an operation?
3. Have you been a patient in the hospital during the past five years?
4. Have you been under the care of a medical doctor within the past five years?

Please list the names & addresses of your doctors:

- 5. Have you ever had any excessive bleeding requiring special treatment?
6. Are you allergic (i.e., itching, rash, swelling of hands, feet or eyes, etc.) or made sick by penicillin, aspirin, codeine, or any other drugs or medications?
7. Are you taking any medicine now? Please list:

8. Please circle any of the following which you have had or have at present:

Table with 4 columns of medical conditions: Heart failure, Anemia, X-ray or cobalt treatment, Hemophilia, Heart disease or attack, Stroke, Chemotherapy (cancer, leukemia), Venereal disease (syphilis, gon.), Angina pectoris, Kidney trouble, Arthritis, Cold sores, High blood pressure, Ulcers, Rheumatism, Genital herpes, Heart murmur, Emphysema, Cortisone medicine, Epilepsy or seizures, Mitral Valve Prolapse, Cough, Glaucoma, Fainting or dizzy spells, Rheumatic fever, Tuberculosis (TB), Pain in jaw joints, Nervousness, Congenital heart lesions, Asthma, Hepatitis A (infectious), Psychiatric treatment, Scarlet fever, Hay fever, Hepatitis B or C (Serum), Sickle Cell disease, Artificial heart valve, Sinus trouble, Liver disease, Bruise easily, Heart pacemaker, Allergies or hives, Yellow jaundice, Artificial joint, Heart surgery, Diabetes, Blood transfusion, Lyme Disease, High Cholesterol, Thyroid disease, Drug Addiction, Migraine Headaches

- 9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath or because you are very tired?
10. Have you lost or gained more than 10 pounds in the last year?
11. Do you ever wake up from sleep short of breath?
12. Are you on a special diet?
13. Has your medical doctor ever said you have a cancer or tumor?
14. Do you have any disease, condition or problem not listed?
15. Do you smoke or chew tobacco? How much?
16. Do you drink alcoholic beverages? How much?
17. Do you wear contact lenses?
18. WOMEN: Are you pregnant now?
Are you practicing birth control?
Do you anticipate becoming pregnant?
When was your last menstrual cycle?

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Patient Signature

Date

William F. Lane, D.M.D./Glenn A. Branca, D.D.S.

Date

# LANE

Oral & Maxillofacial Surgery P.C. & Dental Implant Center

William F. Lane, D.M.D. Glenn A. Branca, D.D.S.

---

---

## Patient Consent Form

---

---

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that Personal Health Information (PHI) is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will take all reasonable precautions to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have to disclose personal health information to laboratories, and other ancillary health care providers for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your Personal Health Information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **PERMISSION TO CONTACT BY PHONE**

I, (print name) \_\_\_\_\_, give permission for Lane Oral Surgery to contact me by phone and, if necessary, leave messages regarding treatment, financial responsibility, and/or appointments.

(Signature) \_\_\_\_\_ Date \_\_\_\_\_

30 Resnik Road  
Plymouth, MA 02360

**508.746.8700**

Fax 508.746.2434

443 Route 130

Sandwich, MA 02563

**508.888.8898**

Fax 508.888.8887

Email: Laneoms@comcast.net

# LANE

Oral & Maxillofacial Surgery P.C. & Dental Implant Center

William F. Lane, D.M.D. Glenn A. Branca, D.D.S.

---

---

## Compliance Assurance Notification for Our Patients

---

---

### **To Our Valued Patients:**

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

30 Resnik Road  
Plymouth, MA 02360

**508.746.8700**

Fax 508.746.2434

443 Route 130

Sandwich, MA 02563

**508.888.8898**

Fax 508.888.8887

Email: [Laneoms@comcast.net](mailto:Laneoms@comcast.net)

# LANE

Oral & Maxillofacial Surgery P.C. & Dental Implant Center

William F. Lane, D.M.D.

Glenn A. Branca, D.D.S

Dear Patient:

Thank you for choosing Lane Oral and Maxillofacial Surgery for your oral surgical care. Our focus is entirely on your comfort, safety, and well-being. In light of this, we have established a policy of taking x-rays in our office in order to have precise and accurate documentation of each patient's status as of the day of his or her examination.

If your doctor has provided a panoramic x-ray which is less than one year old, then you will not be charged for an x-ray in our office; however, if your panoramic x-ray is more than a year old, then a charge will be incurred.

If you have any questions regarding this policy, please ask, and we will be pleased to provide you with answers.

Please sign below.

I understand, and agree with the above policy, and give my permission for treatment including x-rays deemed necessary by the doctor.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date