Mauricio J. Herrera D.D.S.
Board Certified Oral Surgeon

General Patient Information

Today's Date: _____

PATIENT INFORMATION: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name: _____ M.I.: _____ Last Name: _____

Nickname: _____ DOB: _____ Age: _____ Sex: ☐ Male ☐ Female

Physical Address: _____

City: _____ State: _____ Zip: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

Soc. Sec. #: _____ Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Single

Email: _____ Referred By: _____

Dentist: _____ Physician: _____

Emergency Contact Name: _____ Ph #: _____

Regarding HIPAA and health information confidentiality, I give permission to:

☐ Leave voice mail ☐ Send text messages ☐ Send email ☐ Speak with a family member

Spouse: _____ Grandparent: _____

Parent: _____ Other: _____

PERSON RESPONSIBLE FOR ACCOUNT:

First Name: _____ Last Name: _____

S.S. #: _____ DOB: _____ Employer: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

PRIMARY DENTAL INSURANCE INFORMATION: **(If you have an insurance card, please let us know.)**

Insurance Plan Name: _____ Insurance Ph #: _____

Plan ID #: _____ Insurance Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Group #: _____ Group Name: _____

Insured Party First Name: _____ M.I.: _____ Last Name: _____

(This is the person who is employed by the company that provides the insurance.)

S.S. #: _____ DOB: _____

Mailing Address: **(If different from responsible party.)** _____

City: _____ State: _____ Zip: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

Patient's Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Dependent ☐ Parent ☐ Other: _____

Please note that most medical insurance companies do not provide benefits for oral surgery.

Center for Oral and Facial Surgery
& Dental Implants | Glen Allen

Mauricio J. Herrera, D.D.S.
Board Certified Oral Surgeon

Patient Medical History

Patient's Full Name: _____

Today's Date: _____ DOB: _____ Age: _____

Referring Doctor: _____ Insurance: _____

ALLERGIES: **Please check any of the following that you are allergic to or had a reaction to.**

- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Sleeping Pills
- ☐ Codeine/Other Narcotics
- ☐ Aspirin
- ☐ Soy
- ☐ Eggs/Yolk
- ☐ Any Other Allergies Not Listed

Please list any other allergies: _____

_____

- Have you or any relative had a life-threatening reaction to anesthesia? ..... ☐ Yes ☐ No

WOMEN ONLY: Are you pregnant or nursing? ..... ☐ Yes ☐ No

- **Please check any of the following that you have at present or have had in the past.**

- ☐ Damaged/Artificial Heart Valve
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Heart Disease
- ☐ Cardiovascular Disease
- ☐ Heart Attack
- ☐ Angina
- ☐ Coronary Insufficiency
- ☐ Coronary Occlusion
- ☐ High/Low Blood Pressure
- ☐ Arteriosclerosis
- ☐ Stroke
- ☐ Cardiac Pacemaker
- ☐ Prosthetics/Metal Plates/Pins
- ☐ Sinus Trouble/Hay Fever
- ☐ Epilepsy/Fainting Spells/Seizures
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Thyroid Problems
- ☐ Abnormal Bleeding/Anemia
- ☐ Respiratory Problems
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Asthma
- ☐ Arthritis/Painful Swollen Joints
- ☐ Stomach Ulcers/Hyperacidity
- ☐ Sexually Transmitted Disease
- ☐ Cancer

- **Please list any medications you are currently taking.**

Medication Name:	Dosage:	Frequency:

- Have you had any serious illness, operation, or been hospitalized in the last five years? ..... ☐ Yes ☐ No
  If so, please explain: _____
- Have you had a cold or sore throat in the past two weeks? ..... ☐ Yes ☐ No
- Are you wearing contact lenses? ..... ☐ Yes ☐ No
- Are you wearing a removable dental appliance? ..... ☐ Yes ☐ No
- Do you smoke? ..... ☐ Yes ☐ No
- Do you have any disease, condition, or problem not listed above that you think we should know about? ..... ☐ Yes ☐ No
  If so, please explain: _____

CERTIFICATION: I certify that I have read and understand the 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 doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature: _____ Date: _____

CENTER FOR ORAL AND FACIAL SURGERY
FINANCIAL POLICY

Assignment and Release
I the undersigned, have insurance with _____, and assign directly all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Patient Agreement and Financial Policy
I hereby agree to be responsible for the costs of care provided by Center for Oral and Facial Surgery and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that there will be a $35 charge to all accounts in which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. ***For appointments scheduled for 90 minutes or longer, I will be required to make a reservation fee 25% of total surgical procedures prior to scheduling the appointment, which will be applied to my out-of-pocket expense for the appointment. This reservation fee is non-refundable. If I do not show up for my appointment or I do not give adequate notice if I am unable to keep my appointment, the reservation fee will be forfeited. For appointments scheduled for less than 90 minutes, a $50 cancellation fee may apply if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than two hundred and fifty dollars ($250) payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Minor/Child Consent
I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

HIPAA- PATIENT ACKNOWLEDGEMENT FORM
Center for Oral and Facial Surgery & Dental Implants
Glen Allen, Virginia

Center for Oral and Facial Surgery's Notice of Privacy Practices (NOPP) provides information about how we may use and disclose protected health information (PHI) about your child. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NOPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that the terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about your child for treatment, payment and office procedures. You have the right to request that we restrict how PHI about your child is used or disclosed for treatment, payment or office procedures.

I give permission for Center for Oral and Facial Surgery to leave a message or an email regarding an appointment at:

Home: _____and/or

Cell: _____ and/or

Work: _____ and/or

Email: _____

I give permission for Center for Oral and Facial Surgery to share medical/dental information with:

1. Name: _____ Relationship: _____

   Phone: _____

2. Name: _____ Relationship: _____

   Phone: _____

3. Name: _____ Relationship: _____

   Phone: _____

I assume responsibility to inform the practice of any changes in the above information.

Patient's Name (please print): _____ Date: _____

Signature of Parent or Legal Guardian: _____

Center for Oral and Facial Surgery
Notice of Privacy Practices

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.

Center for Oral and Facial Surgery, hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 03/01/2018. You may access or obtain a copy according to the following options: 1) our website at www.oralsurgeryrichmond.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you.

A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.

B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.

C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff.

i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:

D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:

E) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.

F) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.

G) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. If a young adult age eighteen (18)

requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.

H) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:

A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.

B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).

C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.

D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.

E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.

F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer.

G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.

H) Fundraising: If PHI is used for fundraising which is considered "health care operations," basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of another individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

Center for Oral and Facial Surgery & Dental Implants
4805 Lake Brook Drive, Suite #150
Glen Allen, Virginia 23060
Phone: (804)215-1172
Email: Oralsurgeryva@gmail.com

You will not be penalized for filing a complaint.