CAROLINAS CENTER FOR
Oral & Facial Surgery

PATIENT INFORMATION

First Name: ________________________ M.I.: _____ Nickname: ________________ Last Name: _________________________

Sex: ☐Male ☐Female Date of Birth: _______________ Age: ______ Social Security #: ______________________________

Address: ____

City: ____ State: __________ Zip: __________________________

PO Box or Apartment #: ____________ Email Address: ____

Home Phone: ____ Work Phone: ____

Cell Phone: ____ Marital Status: ☐Single ☐ Married ☐ Widowed ☐ Divorced

If Student: ☐ Full-time ☐ Part-Time Name of School: ____

Emergency Contact: ____

Emergency Contact Relationship: ______________________________ Phone: ____

Primary Physician: ____ Phone: ____

Pharmacy: ____

Pharmacy Address: ____ Phone: ____

Dentist: ____ Orthodontist: ____

Referred by: _____________________________________ How did you hear about us? __________________________________

Has a member of your family been seen in our practice? Who? ____

If you are under 18 or a full-time college student, please complete the following information:

Mother's Name: _________________________ Phone Number: (H) __________________________ (W) _________________

Address: ____ Mother's SSN: ______________________________

Father's Name: __________________________ Phone Number: (H) ___________________________ (W) _________________

Address: ____ Father's SSN: ______________________________

Who came with you to the appointment today? ☐ Mother ☐ Father ☐ Other: _______________________________________

Continued on next page.

DENTAL AND MEDICAL INSURANCE

PRIMARY MEDICAL INSURANCE

Do you Have Medical Insurance?: ☐ Yes ☐ No

Insurance Company: ______________________________ Policy #: ____________________ Group #: ____________

Address: ______________________________________ Phone Number: ______________________________

Name of Insured (Policyholder): ______________________________ Insured's Social Security #: ________________________

Insured's Address: ____

Insured's Date of Birth: ________________ Phone #: (H) ____________________(W) ____________________

Insured's Employer: ______________________________ Patient's Relation to Insured: ☐Self ☐ Spouse ☐Child ☐Other

SECONDARY MEDICAL INSURANCE

Insurance Company: ______________________________Policy #: ____________________ Group #: ____________

Address: ______________________________________ Phone Number: ______________________________

Name of Insured (Policyholder): ______________________________Insured's Social Security #: ________________________

Insured's Address: ____

Insured's Date of Birth: ________________ Phone #: (H) ____________________(W) ____________________

Insured's Employer: ______________________________ Patient's Relation to Insured: ☐Self ☐ Spouse ☐Child ☐Other

PRIMARY DENTAL INSURANCE

Do you Have Dental Insurance?: ☐ Yes ☐ No

Insurance Company: ______________________________ Policy #: ____________________ Group #: ____________

Address: ______________________________________ Phone Number: ______________________________

Name of Insured (Policyholder): ______________________________ Insured's Social Security #: ________________________

Insured's Address: ____

Insured's Date of Birth: ________________ Phone #: (H) ____________________(W) ____________________

Insured's Employer: ______________________________ Patient's Relation to Insured: ☐Self ☐ Spouse ☐Child ☐Other

SECONDARY DENTAL INSURANCE

Insurance Company: ______________________________Policy #: ____________________ Group #: ____________

Address: ______________________________________ Phone Number: ______________________________

Name of Insured (Policyholder): ______________________________Insured's Social Security #: ________________________

Insured's Address: ____

Insured's Date of Birth: ________________ Phone #: (H) ____________________(W) ____________________

Insured's Employer: ______________________________ Patient's Relation to Insured: ☐Self ☐ Spouse ☐Child ☐Other

I authorize Carolinas Center for Oral & Facial Surgery to release any information for insurance purposes. I hereby authorize payment directly to Carolinas Center for Oral & Facial Surgery.

____ ____________________

Signature of Patient or Responsible Party Date

I certify that the information on this form is correct. I understand that I am responsible for my balance on this account, even if I have medical and/or dental coverage.

____ ____________________

Signature of Patient or Responsible Party Date

MEDICAL HISTORY

Name of Patient: ______________________________ DOB:__________ Age: _____ Weight: _____ Height:_____ Acct #: ______________

1. Are you allergic to any medicines, latex, eggs, or soybeans? (List any medication and reaction to medication.) ☐ Yes ☐ No

____

____

2. Do you take any medications (prescription or over-the-counter), supplements, or herbal therapy regularly now? ☐ Yes ☐ No

List name, strength, & frequency of current medications: ____

____

____

3. Are you or have you taken medication for decreased bone density? (List below.) .... ☐ Yes ☐ No

____

4. Have you taken any kind of medication regularly during the past year? (List below.) .... ☐ Yes ☐ No

____

5. Have you been a patient in a hospital during the past 2 years?.. ☐ Yes ☐ No
6. Are you now or have you been under the care of a physician during the past 2 years? .... ☐ Yes ☐ No
7. Have you ever had any type of surgery? (List below.).. ☐ Yes ☐ No

____

8. Do you have Advance Directives?.. ☐ Yes ☐ No

9. Check YES or NO as to whether you now or in the past have had problems with and/or treatment for:

☐ YES ☐ NO Heart Trouble	☐ YES ☐ NO Asthma	☐ YES ☐ NO Arthritis
☐ YES ☐ NO Congenital Heart Lesions	☐ YES ☐ NO Breathing	☐ YES ☐ NO Stroke
☐ YES ☐ NO Heart Murmur	☐ YES ☐ NO Diabetes	☐ YES ☐ NO Epilepsy
☐ YES ☐ NO High or low blood pressure	☐ YES ☐ NO Tuberculosis	☐ YES ☐ NO Psychiatric Treatment
☐ YES ☐ NO Anemia	☐ YES ☐ NO Hepatitis	☐ YES ☐ NO Sinus Trouble
☐ YES ☐ NO Rheumatic fever	☐ YES ☐ NO Jaundice	☐ YES ☐ NO Kidney Trouble
☐ YES ☐ NO Drug Use	☐ YES ☐ NO Alcohol Use	☐ YES ☐ NO Immune System Disorder
☐ YES ☐ NO Temporomandibular Joint (TMJ) Disorders		☐ YES ☐ NO Sleep Apnea

OTHER:______________________________

10. Have you ever had any excessive bleeding requiring special treatment?.. ☐ Yes ☐ No
11. If female, are you pregnant? .... ☐ Yes ☐ No
12. Has your physician recommended prophylactic antibiotics prior to dental treatment? .... ☐ Yes ☐ No
13. Have you ever had any artificial joint placed?.. ☐ Yes ☐ No
14. Do you use or have you used tobacco products?.. ☐ Yes ☐ No
15. Do you have a history of alcohol abuse?.. ☐ Yes ☐ No
16. Do you have any medical or dental problems that you think I should know about? (List below.) .... ☐ Yes ☐ No

____

SIGNATURE (of patient or legal guardian) ____ **DATE**: ______________

FOR OFFICE USE: Reviewer ____ Date: ______________

Comments: ____

Update: ____ Date: ______________

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient ______________________________ Date of Birth ______________

Carolinas Center for Oral & Facial Surgery is authorized to release protected health and/or financial information about the above-named patient in the following manner and to identified persons.

Entity to Receive Information. Write each person/entity that you approve to receive information.	**Description of information to be released.** Check what can be given to the person/entity.		
Name/Relationship	All	Treatment	Financial
______________________________	☐	☐	☐
______________________________	☐	☐	☐
______________________________	☐	☐	☐

We may send private health information such as appointment confirmation, procedure instructions, and financial information to your email, your cell phone, your answering machine/or your voicemail. Please indicate the types of communication you are willing to receive.

For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ **EMAIL:** ______________________________

☐ **TEXT (Cell Number Listed on Patient Information Sheet)**

☐ **ANSWERING MACHINE/VOICE MAIL (All Numbers Listed on Patient Information Sheet)**

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization will remain in effect until revoked by the patient.

______________________________ ______________

Patient (or legally authorized individual signature) Date

____

Relationship to patient (parent, legal guardian, etc)

______________________________ ______________

Witness' Signature Date

Notice of Privacy Practices

EFFECTIVE AUGUST 30, 2022

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a healthcare provider, 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 is often referred to as your health or medical record and serves as a basis for planning your care, treatment, and a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand when others may access your health information and for what purpose, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request.
2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment, and health care operations. We reserve the right not to agree to a given requested restriction, unless it pertains to a request that we not disclose your health information to a health plan for payment or health care operations and you have paid in full and out of pocket for the services provided.
3. Request to receive communications of protected health information in confidence.
4. Inspect and obtain a copy of the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request: (i) was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment; (ii) is not part of your medical or billing records; (iii) is not available for inspection as set forth above; or (iv) is accurate and complete. In any event, any agreed-upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. Ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, health care operations, and certain other disclosures (such as any you asked us to make).
7. Revoke an authorization to use or disclose health information except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. Receive notification if affected by a breach of unsecured PHI.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management, and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends, or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition, or death.

Business Associates: There may be some services provided in our organization through contracts with our service providers, called Business Associates. Examples may include billing services, or cloud storage vendors. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, we require all Business Associates to appropriately safeguard your information and comply with HIPAA.

Organ and Tissue Donation: If you are an organ donor, we may disclose medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may disclose protected health information about you for programs that provide benefits for work-related injuries or illness.
Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.
Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge-ordered subpoena. For example, in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.
Military and Veterans: If you are a member of the armed forces, we may disclose protected health information about you as required by military command authorities.
Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful processes.
Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.
Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
Fundraising: Unless you notify us you object, we may contact you as part of a fundraising effort for our practice. You may opt-out of receiving fundraising materials by notifying the practice's compliance department at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fundraising material you receive.
Coroners, Medical Examiners, and Funeral Directors: We may disclose protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose protected health information about patients to funeral directors as necessary to carry out their duties.
Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury, or disability.
Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
Food and Drug Administration (FDA): As required by law, 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, and repairs or replacement.
Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If we make material changes to our information practices, we will send a revised notice to the address you have supplied. Your health information will not be used or disclosed without your written authorization, except as described in this notice and in accordance with law. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Compliance Department at the telephone or email address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Compliance Department at Flagship Specialty Partners or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints. The contact information for both is included below.

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 / Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts/

Flagship Specialty Partners Compliance Dept.
5550 Seventy-Seven Center Dr. Ste 320, Charlotte, NC 28217
855-433-8372
compliance@flagshipsp.com

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be offered a hard copy at the time we first deliver services to you. Thereafter, you may obtain a copy upon request.

CAROLINAS CENTER FOR
Oral & Facial Surgery

A member of

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________________

DOB: _____________ **Patient ID:** ______________________

I understand I may receive a copy of the Notice of Privacy Practices for the above-named practice if I request one.

____ ____________________
Patient or Legal Representative Signature Date

____ ____________________
Patient or Legal Representative Printed Name (if applicable) Relationship to Patient

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices on the following date, _________________ but acknowledgment could not be obtained because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  ____

- ☐ Other:____

  ____

Prepared By ____

Signature ____

CAROLINAS CENTER FOR
Oral & Facial Surgery

OFFICE FINANCIAL POLICY

Thank you for choosing Carolinas Center for Oral & Facial Surgery for your oral surgery needs. Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. Some procedures may be covered under your major medical insurance. Some procedures are covered only under your dental policy.

It is your responsibility to provide all necessary insurance eligibility, identification, and referral information and to notify our office of any information changes when they occur. Failure to provide all required information may necessitate patient payment for all charges.

When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

If you incur a credit balance from a claim, that credit balance will be applied to any outstanding balance on your account before a refund is issued.

You will be responsible for any services not covered by your plan.

Financial arrangements for future treatment will be discussed at the time of your consultation. For most scheduled procedures your estimated co-pay/co-insurance will be required prior to treatment. If your procedure is not covered by your plan, the balance is due in full prior to treatment.

At your request we can file an insurance pre-determination. **Pre-determinations are only estimates and do not always reflect exact reimbursement.**

Some insurance companies, because we are not in their network, will reimburse you directly. Because of this, we may require payment in full for all services.

Payment is due **60 days** after charges are incurred **regardless of insurance payment**. After this time finance charges will be applied to your account at 1-1.5% per month (18%) per year.

All checks returned as "non-sufficient funds" will incur a $30 charge.

Are you covered by MEDICARE Part B?* ☐ **Yes** ☐ **No**
Our Practice is OPTED OUT of MEDICARE. Please reference the Medicare Private Contract for more details.

You will receive monthly statements as a reminder to follow-up with your insurance company. Please contact your insurance company 30 days after services are rendered to be sure your claim is being processed. Insurance reimbursement is ultimately the responsibility of the patient.

In the event of an overpayment, **a refund will be promptly issued to the person listed as the guarantor on the account.**

By signing below, I acknowledge I have read and understand the CCOFS financial policy. I accept full financial responsibility of this account.

____ ____________________
Patient Name Date

____ ____________________
Guarantor Name (if different from patient) Guarantor DOB

____
Guarantor Address

____
City, State, Zip

____ ____________________
Patient/Guarantor Signature **The person who signs will be listed as Guarantor* Date

Driver's License Photo (if, any)

Primary Medical Insurance Photo (if, any)

Secondary Medical Insurance Photo (if, any)

Primary Dental Insurance Photo (if, any)

Secondary Dental Insurance Photo (if, Any)